STANDARDS FOR INSTITUTIONS

Standards to be utilized by state authorities for approval of institutions to participate in Title XIX of the Social Security Act are as follows:

1. Standards established for institutional certification by Title XVIII of the Social Security Act. The types and kinds of institutions in which medical care and services may be provided to eligible recipients are:

   a. Hospitals certified to participate under Title XVIII of the Social Security Act or determined currently to meet the requirements for such participation.

   b. State and private institutions for mental diseases which meet the requirements for a psychiatric hospital under Title XVIII, Section 1861 (f) of the Social Security Act.

   c. State institutions for tuberculosis which meet the requirements for a tuberculosis hospital under Title XVIII, Section 1861 (g) of the Social Security Act.

   d. Skilled nursing facilities certified to participate under Title XVIII of the Social Security Act or determined currently to meet the requirements for such participation.

2. Standards governing Title XIX requirements of participation for intermediate care facilities are described as follows:

   a. Meet federal, state and local laws and hold a current license as an intermediate care facility.

   b. Have an advisory physician or a medical advisory committee composed at least one licensed physician who shall be responsible for advising the administrator on the overall medical management of the patients in the facility.

   c. Have an administrator responsible for the written program of medical services that indicates the scope of care to be provided, the policies relating to, and procedures for implementation of the services.

   d. Assure that each patient is under the supervision of a licensed physician;

   e. Have a Director of Nursing Services responsible for the supervision of the organized nursing staff and the nursing services that are provided in the facility, establishing minimum qualifications for nursing personnel and participating in the development of policies related to patient care.

f. Have procedures for administration of pharmaceutical services in accordance with accepted medical practice.

g. Establish and maintain adequate records which shall include a medical record for each patient, financial records of personal money for each patient, and a permanent chronological patient registry indicating date of admission, discharge, or death.

h. Have a qualified Director of Food Service who is responsible for the provision of dietary services that will maintain adequate nutrition and contribute appreciably to the patients total well-being.

i. Have social services available to assist all residents in dealing with related social problems.

j. Maintain administrative records to reflect expenditures related to food purchase and personnel employed by the facility.

k. Be in compliance with Title VI of the Civil Rights Act of 1964.

Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies

The following is a description of the cooperative arrangements with the State health and State vocational rehabilitation agencies by means of which the services administered or supervised by those agencies will be utilized to the maximum degree and will be coordinated with the medical care and services provided by State agency under the plan:

1. The agreement with the Bureau of Rehabilitation Service, Department of Education, the state vocational rehabilitation agency, provides for fulfillment of the requirements of 42 CFR 431.615. A copy of this agreement is attached. (Attachment 4.16-A.1)

2. The provisions of the agreement between the former Departments of Health and Economic Security fulfill the requirements of 42 CFR 431.615 and continue to remain in force. A copy of this agreement is attached. (Attachment 4.16-A.2)

3. The intracabinet memorandum of agreement with the Department for Health Services provides for preventive and remedial health care services for eligible Medicaid recipients and fulfills the requirements of 42 CFR 431.615.

4. The intracabinet memorandum of agreement with the Department for Mental Health and Mental Retardation Services provides for prescreening, annual resident review, and other administrative functions relating to Preadmission Screening and Annual Resident Review (PASARR) and fulfills the requirements of 42 CFR 431.620.

5. The state agency provides for the coordination of the operations under Title XIX with the state's operations under the special supplemental food program for Women, Infants, and Children under Section 17 of the Child Nutrition Act of 1966 by notifying all Medicaid recipients of the availability of WIC benefits and referring such potential WIC eligible to the WIC Program.

6. The interagency memorandum of agreement with the Commission for Handicapped Children provides for Title V Grantee services and fulfills the requirements of 42 CFR 431.615.

7. The intracabinet memorandum of agreement with the Department for Public Health, the Department for Community Based Services and the Department for Mental Health and Mental Retardation Services provides for targeted case management services for Medicaid eligible recipients including children in the custody of or at risk of being in the custody of the state, and children under the supervision of the state, and adults who may require protective services from the state, and fulfills the requirements of 42 CFR 431.615.

8. The intracabinet memorandum of agreement with the Department for Public Health, the Department for Community Based Services and the Department for Mental Health and Mental Retardation Services provides for rehabilitative services for children in the custody of or at risk of being in the custody of the state, and for children under the supervision of the state, and fulfills the requirements of 42 CFR 431.615.

9. The interagency agreements with the Commission for Children with Special Health Care Needs and the Department for Public Health provide for targeted case management, and diagnostic, preventive, and rehabilitative early intervention services for Medicaid eligible recipients participating in the Kentucky Early Intervention Program for infants and toddlers, and fulfills the requirements of 42 CFR 431-615.

10. The Title V interagency agreement with the Department for Public Health provides for targeted case management to first time parenting pregnant women and their infants and toddlers up to three (3) years of age. Eligible recipients are those women and their infants that screen positive on the screening tool adopted for use in the Health Access Nurturing Development Services (HANDS) program.

A G R E E M E N T

This Agreement is for the purpose of clarifying the relationship between a program of rehabilitation services administered through the Bureau of Rehabilitation Services of the Kentucky Department of Education and a program of medical assistance administered by the Department of Economic Security, in cooperation with the State Department of Health, under Title XIX of the Social Security Act. The Agreement also serves to formalize procedures and practices that are presently in force between the Department and the Bureau. A cooperative relationship has long existed between the two Agencies in the matter of services to and referral of mutual clients.

The Department and Bureau agrees to use the facilities of each Agency for rehabilitating applicants and recipients of medical and financial assistance. This includes sharing of information between agencies on mutual clients and to respect the confidential nature of information made available by either Agency.

In recognition of the fact that a very large number of individuals who receive services from the Bureau will be eligible for medical care benefits administered by the Department, staff of the Bureau will be alert to referral to the Department of individuals who may qualify for such benefits. Staff of the Department will refer to the Bureau those recipients who are in need of rehabilitation services.

Title XIX funds will be used to pay for medical services, within the scope of the Department's program, which are a part of the plan of treatment and rehabilitation of individuals eligible under Title XIX. The Bureau will thus be enabled to broaden the benefits of its program to individuals in need of service who are not eligible for Title XIX benefits, or to provide additional supplementary benefits. Except, Bureau funds will be used in the event of necessity to maintain quality of care.

Policies of either Agency known to effect the cooperative work of the agencies will be jointly evaluated. Plans to effect policy changes needed to achieve joint goals will be joint efforts.

The Bureau and the Department hereby agree to direct all other of their activities toward using the resources of the two Agencies to the best advantage of clients served jointly.

/s/ Ben F. Coffman
Ben F. Coffman
Assistant Superintendent
Bureau of Rehabilitation Service
Department of Education

6/14/66
Date

/s/ C. Leslie Dawson
C. Leslie Dawson
Commissioner
Department of Economic Security

6/14/66
Date

CONTRACT

THIS AGREEMENT entered into this 27th day of December, 1960, between the Department of Economic Security, party of the first part, and the State Department of Health, party of the second part, is made pursuant and subject to the provisions of Sections 205.510 to 205.610, 205.991 and 211.106 of the Kentucky Revised Statutes:

WITNESSETH:

WHEREAS, the 1960 General Assembly of the Commonwealth of Kentucky by the enactment of Sections 205.510 - 205.610, 205.991 and 211.106 of the Kentucky Revised Statutes, has recognized and declared that it is an essential function, duty and responsibility of the Commonwealth of Kentucky to provide medical care to its indigent citizenry; and

WHEREAS, the General Assembly has directed that the Department of Economic Security shall contract with the State Department of Health for the purpose of carrying out the medical aspects of the Medical Care Program for Indigent Persons in accordance with the intent of said Sections 205.510-205.610, 205.991 and 211.106 of the Kentucky Revised Statutes;

NOW, THEREFORE, in consideration of the covenants and premises hereinafter set out, the parties hereto, in order to implement, carry out and fulfill the duties and responsibilities placed upon the parties by the enactment into law of the Medical Care Program for Indigent Persons do agree as follows:

1. The party of the first part will provide funds to the party of the second part, within limitations to be hereafter agreed to from time to time by the parties, giving consideration to existing budgetary conditions for all actual, necessary expenses which second party incurs in carrying out the duties and responsibilities outlined herein.

2. The party of the second part shall carry out the medical care aspects of the Program and in doing so will among other things:

a. certify that services rendered are in accordance with quantity and quality standards as established;

b. certify to the Department of Economic Security that medical services have been rendered by qualified vendors;

c. develop and maintain manuals of policies, procedures, and instructions for the operation of the medical aspects of the Program;

d. develop bases of payment for medical care and any alterations therein; and certify vendor billings for compliance with bases of payment as established;

10-1-73

74-1

e. evaluate the medical aspects of the Program, and assist in the evaluation of the total Program, and in preparing recommendations for alterations therein;

f. establish and maintain separately or jointly with first party statistical procedures and methods for the accumulation of accurate records on utilization of the Program; and for use as a control technique in the enforcement of quality and quantity standards; and for use in the evaluation of the Program and recommendations for alterations therein;

g. prepare periodic program reports and other reports and materials;

h. provide staff assistance to the Advisory Council for Medical Assistance;

i. work with the technical advisory committees and county medical review committees as they carry out their functions;

j. develop and recommend rules and regulations pertaining to quality and quantity standards for medical aspects of the Program;

k. jointly with the first party establish and maintain effective channels for the dissemination of information regarding the Program to professional organizations involved and to the public;

l. assist local health departments in working with community groups and organizations interested in the Medical Care Program;

m. perform all other duties required of said second party by law or regulations promulgated thereunder, and all other duties agreed to by the parties.

3. In the event the appropriate funds become insufficient to provide medical services on a uniform basis pursuant to this contract, the Department of Health shall consult with and advise the Department of Economic Security as to the best method of expenditure reduction and upon the manner and method of reduction of medical services for the duration of such insufficiency of funds. In like manner, in the event that appropriated funds are over and above the amount necessary to provide medical services in accordance with established regulations, the Department of Health shall consult with and advise the Department of Economic Security as to the method of expanding services provided and upon the manner and method of expansion of medical services for the duration of such surplus of funds.

7-1-73

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4. The parties hereto further agree that second party will maintain adequate records of administrative expenditures and should a Federal audit exception be taken to an administrative expenditure made by second party, and said exception later sustained, then second party shall refund to first party the amount of the excepted expenditure.

This Agreement shall continue in full force and effect until terminated in writing by both parties or cancelled by either party upon written notice to the other party given at least sixty (60) days prior to the designated termination date, at which time both parties shall enter into a new contract.

IN TESTIMONY WHEREOF, the party of the first part has caused this instrument to be executed by Jo M. Ferguson, its Commissioner, and the party of the second party by Russell E. Teague, M.D., its Commissioner, the day and date first above written.

Approved: /s/ William L. Brooks

Asst. Attorney General
Department of Finance

DEPARTMENT OF ECONOMIC SECURITY
Party of the First Part

Approved: /s/ Maurice P. Carpenter

Director of Purchases

By /s/ Jo M. Ferguson

Jo M. Ferguson
Commissioner

Approved: /s/ Robert Matthews, Jr.

Commissioner of Finance

STATE DEPARTMENT OF HEALTH
Party of the Second Part

By /s/ Russell E. Teague, M.D.

Russell E. Teague, M. D.
Commissioner

10-1-73

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge Deduct.	Coins	Co-pay	Amount and Basis for Determination
Prescription Drugs			X	$1.00 for each prescription for which the Department reimburses a dispensing fee. The average payment per prescription drug is $43.47 in FY 2001.

Service	Type of Charge Deduct.	Coins.	Co-pay	Amount and Basis for Determination
Audiology			X	$2.00 for each date of service The average payment for these service categories is $100.01 in FY 2002.
Chiropractor			X	
Dental			X	
Hearing			X	
Podiatry			X	
Optometry			X	
General ophthalmological services *			X	

* CPT codes 92002, 92004, 92012, and 92014.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

B. The method used to collect cost sharing charges for medically needy individuals:

X Providers are responsible for collecting the cost sharing charges from individuals.

_ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Federal limits on the services for which copayment applies restrict the maximimum copayment charges. The State's scope of services is broad and eligible recipients have low, if any, out-of-pocket medical expenses; therefore, the state believes that all recipients within the class that are subject to copayments should be able to pay the required copayment.

Should a recipient claim to be unable to pay the required copayment, the provider may not deny service, but may arrange for the recipient to pay the copayment at a later date. Any uncollected amount is considered a debt to providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

MMIS has been programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.53(b). MMIS will identify the exempt recipients by age for children under age 18, by aid category and recipient status for pregnant women and institutionalized individuals. Recipients outside the exempt status will have a copayment due and printed on the Medicaid cards they receive each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

E. Cumulative maximums on charges:

X State policy does not provide for cumulative maximums.

_ Cumulative maximums have been established as described below:

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Co-pay	
Prescription Drugs			X	$1.00 for each prescription for which the Department reimburses a dispensing fee. The average payment per prescription drug is $43.47 in FY 2001.

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Co-pay	
Audiology			X	$2.00 for each date of service The average payment for these service categories is $100.01 in FY 2002.
Chiropractor			X	
Dental			X	
Hearing			X	
Podiatry			X	
Optometry			X	
General ophthalmological services *			X	

*CPT codes 92002, 92004, 92012, and 92014.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

B. The method used to collect cost sharing charges for medically needy individuals:

X Providers are responsible for collecting the cost sharing charges from individuals.

_ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Federal limits on the services for which copayment applies restrict the maximum copayment charges. The State's scope of services is broad and eligible recipients have low, if any, out-of-pocket medical expenses; therefore, the state believes that all recipients within the class that are subject to copayments should be able to pay the required copayment.

Should a recipient claim to be unable to pay the required copayment, the provider may not deny him service, but may arrange for the recipient to pay the copayment at a later date. Any uncollected amount is considered a debt to providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

MMIS has been programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.53(b). MMIS will identify the exempt recipients by age for children under age 18, by aid category and recipient status for pregnant women and institutionalized individuals. Recipients outside the exempt status will have a copayment due and printed on the Medicaid cards they received each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

E. Cumulative maximums on charges:

X State policy does not provide for cumulative maximums.

_ Cumulative maximums have been established as described below:

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

Not Applicable

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

Not Applicable

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

C. State or local funds under other programs are used to pay for premiums:

[ ] Yes [X] No

D. The criteria used for determining whether the agency will waive payment o a premium because it would cause an undue hardship on an individual are described below:

Not applicable

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

Not applicable

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

Not applicable

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

C. State or local funds under other programs are used to pay for premiums:

/ / Yes /X/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

Not applicable

*Description provided on attachment.

A. The Department for Medicaid Services shall pay for inpatient hospital services provided to eligible recipients of Medicaid through the use of rates that have been established in accordance with Section 1902(a)(13)(A) of the Social Security Act.

B. The methods and standards used by the state agency are specified in Attachment 4.19-A, Exhibit A. For any reimbursement issue or area not specified in Exhibit A, the retrospective Medicare standards and principals shall apply, with the Medicare inpatient routine nursing salary cost differential paid under 42 CFR 405.430 excluded.

C. The state shall comply with the requirements shown in 42 CFR 447.250 through 447.280.

D. The methods, standards, upper limits and reimbursement principles for disproportionate share hospitals are specified in Attachment 4.19-A, Exhibit A.

E. Payments to Participating Out-of-State Hospitals.

(1) Participating out-of-state hospitals shall be reimbursed for covered inpatient services rendered to eligible Kentucky Medicaid recipients at the rate of seventy-five (75) percent of usual and customary charges, up to the in-state per diem upper limit for a comparable size hospital, except as specified in subsection (2) of this section.

(2) Payment limits shall be set for participating out-of-state hospitals at the rate of eighty-five (85) percent of usual and customary actual billed charges up to 110 percent of the per diem upper limit for the in-state peer group for comparably sized hospitals for days of stay which for newborns are after thirty (30) days beyond the date of discharge for the mother of the child and for all other children are after thirty (30) days after the date of admission in accordance with the following:

(a) for infants under the age of one (1) in any hospital; and
(b) for children under the age of six (6) in disproportionate share hospitals.

(3) Professional costs for all covered days of stay shall be paid at seventy-five (75) percent of the usual and customary charges of the provider.

F. Special provisions relating to payments for the period of January 1, 1997 and June 30, 1997.

(1) Effective for the period beginning on January 1, 1997 and ending on June 30, 1997 the facilities' payment rates shall be computed as being the rate in effect for January 1, 1996, with the operating and professional components of the rate indexed forward to June 30, 1997.

(2) Included in the January 1, 1997 through June 30, 1997 rate will be an add-on equal to 15% of the difference between the lesser of the operating cost per diem or the maximum operating per diem and the operating per diem as limited by the rate of increase control that is reflected on the 1996 individual rate notices.

(3) For the period of January 1, 1997, through June 30, 1997 the rate of increase control is removed from the capital component of the rate.

G. Effective July 1, 1997, the universal rate year shall be July 1 through June 30.

b. The hospital must have the greatest number of Medicaid inpatient days of any hospital in the State, in the previous fiscal year.

During this year such a hospital, shall be allowed a limit that is 200% of the limit described in OBRA '93.

L. Effective February 20, 1995, to be classified as a Type III hospital, a university teaching hospital must make a request to the Department for Medicaid Services for Type III status.

M. To qualify for the base payment of $200,000 as outlined in J. 2., hospitals must submit to the Cabinet a written commitment and a description of a planning approach by the hospital to work with local health department(s) and other appropriate providers to provide medical services to the indigent. This plan shall be based on community health needs assessment using a methodology approved by the Cabinet. This plan shall be submitted for review by the Cabinet and the General Assembly's Interim Committee on Health and Welfare no later than June 30, 1995.

N. Hospitals shall submit, by the 15th of the month following the end of the quarter, reports to the Department for Medicaid Services. These reports shall indicate the number of indigent patients treated for the prior quarter and the costs associated with their care.

O. For the period beginning July 1, 2000, disproportionate share hospital payments shall be made according to the following:

1. Hospitals shall be classified according to the following:
   a. Type I hospitals shall be hospitals with 100 beds or less;
   b. Type II hospitals shall be hospitals with more than 100 beds that are not Type III or Type IV hospitals;
   b. Type III hospitals shall be state university teaching hospitals; and
   c. Type IV hospitals shall be state-owned psychiatric hospitals.

2. Annually the department shall determine a sum of funds to be appropriated to each classification of hospitals in accordance with state and federal law.

3. Disproportionate share hospital payments shall be fully prospective amounts determined in advance of the state fiscal year to which they apply, and shall not be subject to settlement or revision based on changes in utilization during the year to which they apply. Payments prospectively determined for each state fiscal year shall be considered payment for that year, and not for the year from which patient and cost data used in the calculation was taken.

4. For SFY 2000-2001, the department shall use patient and cost data from the period of October 1998 to September 1999 in the determination of amount payable to Type I and Type II hospitals. Subsequent years payment shall use patient and cost data from the most

recently completed state fiscal year. DSH payments determined under this methodology shall be made on an annual basis.

5. Distributions to a Type I and Type II hospital be based upon each hospital's proportion of costs determined as follows:

$$\frac{\text{Indigent Costs}}{\text{Total Indigent Costs for Type I and Type II hospitals}} \times \text{Available Fund} = \text{DSH Payment}$$

6. Disproportionate share hospital payments made to Type III and Type IV hospitals shall be based upon each facilities historical percentage of costs as applied to current patient and cost data. Payments made to a Type III hospital shall be equal to the sum of the costs of providing services to Medicaid patients, less the amount paid under nondisproportionate share provisions and the costs of services to uninsured indigent patients, less any payments made. Payments shall be made on an annual basis.

Distributions to a Type III and Type IV hospital shall be based upon available funds as appropriated under O. 2., according to the following :

$$\frac{\text{Indigent Costs}}{\text{Total Indigent Costs for Type III hospitals}} \times \text{Available Fund} = \text{DSH Payment}$$

And:

$$\frac{\text{Indigent Costs}}{\text{Total Indigent Costs for Type IV hospitals}} \times \text{Available Fund} = \text{DSH Payment}$$

7. The disproportionate share hospital payment shall be an amount that is reasonably related to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(7) Payments to Participating out-of-state Hospitals

A. Effective with regard to services provided on or after July 1, 1990, participating out-of-state hospitals shall be reimbursed for covered inpatient services rendered eligible Kentucky Medicaid recipients at the rate of seventy-five (75) percent of usual and customary charges, up to the in-state per diem limit for a comparable size hospital, except as specified in (b).

B. Effective with regard to medically necessary hospital inpatient services provided on or after July 1, 1991, to infants under the age of one (1), and for children under the age of six (6) in disproportionate share hospitals (determined in the same manner as for in-state hospitals except that out-of-state hospitals are not included in facility arrays) for days of stay which for newborns are after thirty (30) days beyond the date of discharge for the mother of the child and for all other children are after thirty days from the date of admission, participating out-of-state hospitals shall be paid at the rate of eighty-five (85) percent of the usual and customary actual billed charges up to 110 percent of the per diem upper limit for the in-state peer group for

comparable sized hospitals in recognition of exceptionally high costs and lengths of stay related to infants under the age of one (1), and children under age six (6) without regard to length of stay or number of admissions of the infants children.

C. Professional costs (i.e., physician fees) for all covered days of stay shall be paid at seventy-five (75) percent of the usual and customary charges of the provider.

Special Payment Rates and Upper Limits Period

(8) Provider taxes shall be considered allowable cost. For the rate period beginning July 1, 1993, the allowable cost of the tax shall be added to the hospital rate with no offsets. For subsequent rate periods the cost (excluding, effective March 1, 1994, any perdiem rate adjustment for the prior rate period relating to provider taxes) shall be shown in the appropriate cost report with adjustment as necessary to reflect an annual amount.

(9) Allowable cost growth from the prior rate base year to the new rate base year shall be limited to not more than one and one-half (1 1/2) times the Data Resources, Inc. inflation amount for the same period; limits shall be applied by component (capital and operating cost only); cost growth beyond the allowable amounts shall be considered unallowable cost for rate setting purposes.

Hospital Reimbursement Methodology for State Fiscal Year 2000-2001

1. The reimbursement rate for acute care and rehabilitation hospitals for the rate year beginning July 1, 2000 shall be determined by utilizing a rate on rate methodology. The rate shall be determined by the department as follows:
   a. The department shall utilize a hospital's June 30, 2000 per diem rate that includes operating, professional, and capital cost components.
   b. The per diem rate shall be multiplied by the rate of increase of 2.8%. This rate of increase is determined by an analysis of current rates, utilization, inflation as measured by the Data Resources, Inc. (DRI), and annual budgetary limits.
2. Payments to psychiatric hospitals shall not be subject to this rate on rate methodology. Their rates shall be determined using the methodology as described in Attachment 4.19-A, Exhibit A.
3. Acute care hospitals that have been relicensed as critical access hospitals shall be paid for inpatient services through a per diem rate as established by HCFA for the Medicare program. The per diem rate shall include operating, professional, and capital cost components. Any revisions to this rate shall reflect revisions made by Medicare. Total payments made to a critical access hospital shall be subject to the payment limitation in 42 CFR 447.271.

Hospital Reimbursement Methodology for State Fiscal Year 2001-2002

1. The reimbursement rate for acute care and rehabilitation hospitals for the rate year beginning July 1, 2001 shall be as follows:
   a. The rate in effect on June 30, 2001.
   b. Include an operating, capital, and, if applicable, professional component.
2. The reimbursement rate for psychiatric hospital for the rate year beginning July 2, 2001, shall be the lessor of:
   a. The rate established using the methodology as described in Attachment 4.19-A, Exhibit A; or
   b. The rate in effect on June 30, 2001.
3. Acute care hospitals that have been relicensed as critical access hospitals shall be paid for inpatient services through a per diem rate as established by HCFA for the Medicare program. The per diem rate shall include operating, professional, and capital cost components. Any revisions to this rate shall reflect revisions made by Medicare. Total payments made to a critical access hospital shall be subject to the payment limitation in 42 CFR 447.271.

Hospital Reimbursement Methodology for State Fiscal Year 2002-2003

1. The reimbursement rate for acute care and rehabilitation hospitals for the rate year beginning July 1, 2002, shall be the rate in effect on June 30, 2002.

2. Except for a state-owned or operated psychiatric hospital, the reimbursement rate for a psychiatric hospital for the rate year beginning July 1, 2002 shall be the rate in effect on June 30, 2002.

3. For a state-owned or operated psychiatric hospital, rates shall be determined using the methodology as described in Attachment 4.19-A, Exhibit A.

4. Acute care hospitals that have been relicensed as critical access hospitals shall be paid for inpatient services through a per diem rate as established by CMS for the Medicare program. Any adjustments to this rate shall reflect adjustments by Medicare. Total payments made to a critical access hospital shall be subject to the payment limitation in 42 CFR 447.271.

5. Out-of-state hospitals shall be reimbursed for services at the lesser of:
   (a) Seventy-five (75) percent of usual and customary charges; or
   (b) A per diem rate equal to the in-state operating per diem upper limit for a comparable size hospital.

   A provision shall also be made for capital cost that is equal to the mean capital cost per diem for the appropriate peer group based on the number of beds licensed. In addition, a professional component, if applicable, shall be paid at seventy-five (75) percent of charges.

(10) Public Process for Determining Rates for Inpatient Hospitals

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

(11) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

(A) Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A

(B) Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

(1) The PRTFs shall be paid a fixed per diem rate of $230 which shall be adjusted upward each biennium by 2.22 percent or the usual and customary charge, if less. The payments shall not exceed prevailing charges in the locality for comparable services provided under comparable circumstances. The fixed rate (upper limit) is the state's best estimate of the reasonable and adequate cost of providing the services. This rate is.determined in the following manner:

(a) Facilities that provide services that meet the criteria for PRTFs are requested to submit their actual costs for covered services. These costs shall include all care and treatment, staffing, ancillary services (excluding drugs), capital, and room and board costs.

(b) The actual costs submitted by the facilities are compared to the costs estimated to operate a model PRTF. The costs of the model facility and current facilities are analyzed on the basis of their being reasonable and adequate to meet the costs which would be incurred in order to provide quality services in an economic and efficient manner.

(c) From this analysis and a consideration of the comments from the facilities, a uniform per diem rate is established for all participating facilities.

(d) This per diem rate is then adjusted for inflation by 2.22 percent biennium. This inflation rate is based upon the historic rate of inflation as applied to these facilities and their necessary increases in costs of providing the services.

(2) The fixed rate or usual and customary charge, if less, covers total facility costs for PRTF services including the following: all care and treatment costs, staffing, costs for ancillary services (except drugs), capital costs, and room and board costs. The rate is established to be fair and adequate compensation for services provided to Medicaid beneficiaries.

(12) Intensity Operating Allowance Inpatient Supplement.

During the final quarter of SFY 1999, instead of the additional payment amount provided for under Section (5)B.2 of this attachment, any qualifying hospital that meets the additional criteria of a Type III hospital as described in Attachment 4.19-A, Exhibit A, Section 102B.(d) (3), shall receive a supplemental payment for the current rate year. This supplement shall be an amount established according to the following method and shall be distributed to qualifying hospitals as described below.

A qualifying hospital's pediatric teaching supplement =
2% of the per diem rate X Medicaid utilization rate X Medicaid patient days.

Medicaid utilization rate for the above calculation is the rate derived by dividing a hospital's total Medicaid days by the total patient days. *Medicaid patient days* include days reimbursed through a managed care entity and the fee-for-service reimbursement methodology.

Any payments made under this section are subject to the payment limitation as specified in 42 CFR 447.271 whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

Subsequent payments made under this section shall be prospectively determined quarterly amounts and shall be subject to the same limitations and conditions as above.

In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.

(12) Intensity Operating Allowance Inpatient Supplement (cont.)

Instead of the payment described in Attachment 4.19-A, Exhibit A, page 102B.03 a state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

1. Determined on a per diem or per discharge basis equal to the unreimbursed costs of providing care to Medicaid recipients under the age of 18: plus

2. $250,000 ($1 million annually).

Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.

13) Payment Not To Exceed Charges

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges-plus-disproportionate share.

14) Limit on Amount of Disproportionate Share Payment to a Hospital

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. The amount of disproportionate share payments that exceed this limit shall be determined retrospectively after a hospital completes its fiscal year. (Section 1923 (g) of the Social Security Act.)

Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments. If payments exceed costs, the financial gain from Medicaid will not be applied against the unrecovered cost of uninsured/indigent patients.

Unrecovered Cost of Uninsured/Indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by them. If payment exceeds cost, the financial gain will not be applied against the Medicaid payment shortfall. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.

(15) Supplemental Payment for Urban Trauma Center Hospitals

Supplemental payments are provided for any Type III hospital as described in Attachment 4.19-A, Exhibit A, Section 102B.(d)(3) that qualifies as an urban trauma center hospital. A hospital qualifies as an urban trauma center hospital if it meets the following:

1. The hospital is designated as a Level I Trauma Center by the American College of Surgeons;
2. The hospital has a Medicaid utilization rate greater than 25%.
3. At least 50% of its Medicaid population are residents of the county in which the hospital is located.

An annual fixed payment pool will be established based on the state matching contribution made available for this purpose by other state sources. The payments will be made based on the following methodology:

$$\frac{\text{Medicaid Patient Days}}{\text{Total Medicaid Patient Days}} \times \text{Available Funds} = \text{Payment}$$

Medicaid patient days included in the payment are a hospital's days reimbursed under fee-for-service attributable to recipients who are not eligible for services under the state's Section 1115 waiver. *Total Medicaid patient days* include all Medicaid patient days for all qualifying hospitals.

Medicaid utilization rate for the above calculation is the rate derived by dividing a hospital's total Medicaid days by the total patient days, which includes days reimbursed through a managed care entity and fee-for-service.

Any payments made under this section are subject to the payment limitation as specified in 42 CFR 447.271 whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals to qualify for FFP.

(16) Upper Payment Limit

The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits.

(17) Supplemental Payments for Psychiatric Access Hospitals

For services provided on and after April 2, 2001 the Department shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas of the Commonwealth. To qualify for psychiatric access payments a hospital must meet the following criteria:

1. The hospital is not located in a Metropolitan Statistical Area (MSA):

2. The hospital provides at least 65,000 days of inpatient care as reflected in the Department's Hospital Rate data for Fiscal Year 1998-99;

3. The hospital provides at least 20% of inpatient care to Medicaid eligible recipients as reflected in the Department's Hospital Rate data for State Fiscal Year 1998-99; and

4. The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.

Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds available for these payments. Payments will be made on a quarterly basis in according with the following:

$$\frac{\text{Medicaid patient days}}{\text{Total Medicaid patient days}} \times \text{Available Fund} = \text{Payment}$$

Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The available fund shall be an amount not to exceed $6 million annually.

(18) Supplemental Payments for Non-state Government-owned Hospitals.

The Department provides quarterly supplemental payments to certain non-state government-owned hospitals for services provided to Medicaid patients. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for services to Medicaid patients and the maximum amount allowable under applicable federal regulations in accordance with 42 CFR 447.272.

To qualify for a supplemental payment, a hospital must be a non-state government-owned hospital and must have entered into an Intergovernmental Transfer Agreement with the Commonwealth. The payment amount for a qualifying hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's Medicaid days provided during the most recent fiscal year by the total Medicaid days provided by all qualifying hospitals for the same fiscal year.

A payment made to a hospital under this provision when combined with other payments made under the non-disproportionate provisions of the state plan shall not exceed the limit specified in 42 CFR 447.272.

(19) Supplemental Payments for Private Hospitals

Private hospitals (non-government owned or operated) qualify to receive supplemental payments from a pool in an amount to be determined annually by the Department. The Department will establish a pool in an amount equal to (a) one-half of the payments made to participating facilities under (18) of Attachment 4.19-A, page 14, and section F of Attachment 4.19-B, page 20.12(g) after (b) deducting the non-federal share of the payments, less the funds necessary to reimburse the participating facilities' Medicaid "shortfall ", [defined as the difference between their aggregate payments for all inpatient hospital services (exclusive of disproportionate share payments) and their aggregate allowable costs of providing inpatient hospital services]. This amount shall be matched with federal financial participation to establish the total fund.

The supplemental payments shall be made quarterly and distributed proportionately among qualifying hospitals to the extent of their Medicaid costs as compared to the total Medicaid costs of all qualifying hospitals, not to exceed its "shortfall". The pool will be distributed pro rata, so that each qualifying hospital will receive a percentage of the pool equal to its pro rata share of the aggregate Medicaid costs of all qualifying hospitals.

The "shortfall" will be calculated on a per diem or per discharge basis, using the most recent cost reports used to establish hospital rates, and applied to claims data from the MMIS for the most recently completed fiscal year. Revenues or costs associated with days of care provided under managed care arrangements shall not be considered in determining the shortfall.

CABINET FOR HEALTH SERVICES

DEPARTMENT FOR MEDICAID SERVICES

MEDICAID REIMBURSEMENT MANUAL FOR HOSPITAL INPATIENT SERVICES

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621-0001

TABLE OF CONTENTS

Section 100. INTRODUCTION

A cost-related, prospective payment system for hospitals providing inpatient services for Title XIX (Medicaid) recipients, to be reimbursed under the Kentucky Medicaid Program (program) of the Department for Medicaid Services (department), is presented in this manual. If not otherwise specified, this system utilizes allowable cost principles of the Title XVIII (Medicare) Program. This payment method is designed to achieve three major objectives:

(1) to assure that needed inpatient hospital care is available for eligible recipients and indirectly to promote the availability of this care for the general public,

(2) to assure program control and cost containment consistent with the public interest, and

(3) to provide an incentive for efficient management.

Under this system, payment shall be made to hospitals on a prospectively determined basis for the total cost of inpatient care with no year-end cost settlement required. The basis of this prospective payment shall be the most recent Medicaid cost report (HCFA-2552) available as of November 1 of each year, trended to the beginning of the rate year and indexed for inflationary cost increases which may occur in the prospective year.

TN # 97-03
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TN # 95-11

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In addition, a maximum upper limit shall be established on all inpatient operating costs exclusive of capital costs and professional component costs. For purposes of applying an upper limit, hospitals shall be peer grouped according to bed size with allowances made in recognition of hospitals serving a disproportionate number of poor patients. Another feature of the prospective system is a minimum occupancy factor applied to capital costs attributable to the Medicaid program.

If unaudited data is utilized to establish the universal rate, the rate shall be revised when the audited base year cost report is received from the fiscal intermediary or an independent audit firm under contract with the Department for Medicaid Services.

The payment system is designed to provide for equitable payment levels for the various peer groups of hospitals, and will directly result in the use of rates that are reasonable and adequate for efficiently and economically operated hospitals while providing services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

Section 101. PROSPECTIVE RATE COMPUTATION

The prospective system is based on a universal rate year which is set for all hospitals using the most recent cost report data available as of November 1 of each year, trended to the beginning of the rate year and indexed (adjusted for inflation) for the prospective rate year. Rates based on unaudited data shall be revised upon receipt of the audited base year cost report from the fiscal intermediary or an independent audit firm under contract with the Department. Prospective rates include both inpatient routine and inpatient ancillary costs and shall be established taking into account the following factors:

(a) Allowable Medicaid inpatient cost and Medicaid inpatient days based on Medicare cost finding principles shall be utilized. Medicaid inpatient operating costs, excluding Medicaid inpatient capital costs and Medicaid professional component costs, shall be trended to the beginning of the rate year. The Medicaid inpatient capital cost is later used in determining a capital cost per diem. The Medicaid inpatient professional component costs shall be trended to the beginning of the rate year separately from the inpatient operating costs.

(b) Medicaid inpatient capital costs based on Medicare cost finding principles shall be utilized except that Medicaid inpatient building and fixtures depreciation cost is defined as sixty-five (65) percent of the amount reported for building and fixtures.

(c) Allowable Medicaid inpatient operating costs, excluding those fixed costs associated with capital expenses and professional component costs, shall be increased by the hospital inflation index to project current year inpatient operating costs.

(d) A Medicaid inpatient operating cost per diem shall be computed utilizing the Medicaid inpatient operating cost and Medicaid inpatient days.

(e) An upper limit shall be established on inpatient operating costs at the weighted median inpatient cost per diem for hospitals in each peer group, except as otherwise specified in Section 102. For purposes of applying n upper limit, hospitals shall be peer grouped according to licensed bed size. The peer groupings shall be: 0-50 beds, 51-100 beds, 101-200 beds, 201-400 beds, and 401 beds and up. Peer grouping shall be based on the number of Medicaid licensed hospital beds at the time of rate setting.

(f) A Medicaid inpatient capital cost per diem shall be computed using Medicaid inpatient capital costs and Medicaid inpatient days. Allowable Medicaid capital costs shall be reduced if the minimum occupancy factors are not met by artificially increasing the occupancy factor to the minimum factor, and calculating the capital costs using this minimum occupancy factor.

1. A sixty (60) percent occupancy factor shall apply to hospitals with 100 or fewer beds.

2. A seventy-five (75) percent occupancy factor shall apply to hospitals with 101 or more beds.

(g) Allowable Medicaid professional component costs shall be increased by the inflation index (DRI/McGraw-Hill Hospital Market Index) to project current year professional component costs. A Medicaid inpatient professional component cost per diem shall be computed utilizing the Medicaid inpatient professional component costs and Medicaid inpatient days;

(h) For acute care hospitals the allowable rate growth from the prior rate year

to the new rate year shall be limited to not more than one and one-half times the Data Resources, Inc. (DRI) inflation amount for the same period; limits shall be applied by component (operating and capital cost components only); rate growth beyond the allowable amount shall be considered unallowable for rate setting purposes.

(i) The prospective inpatient rate shall be the sum of the allowable inpatient operating cost per diem, the allowable inpatient capital cost per diem, and the allowable professional component per diem.

(j) If a review or appeal decision results in the revision of a rate, any additional operating cost not included in the base year cost report shall be offset by the amount allowed for trending and indexing in the following manner:

(1) If the cost increase is incurred prior to the rate year in question, the additional operating cost shall be offset by the amount allowed for trending and indexing.

(2) If the cost increase was incurred during the rate year in question, the additional operating cost shall be offset by the amount allowed for indexing.

For the rate period beginning January 1, 1997, the rates shall be the rate in effect for January 1, 1996 with the operating and professional components of the rate indexed forward for the 1997 rate period. Additionally, there shall be an add-on to the rate, computed as fifteen (15) percent of the amount between the lessor of the operating cost per diem and the maximum operating per diem as limited by the rate of increase control (1 ½ times the DRI) that is reflected on the 1996 individual Medicaid hospital rate notices. The capital component shall not be indexed, however, the capital component of the rate shall be the amount computed for capital cost in the 1996 individual Medicaid hospital rate notices, excluding the application of the rate of increase control (1 ½ times the DRI). The indexing factor to be used for the rate setting process for the period beginning January 1, 1997 shall be the inflation factor prepared by DRI for the same period.

Section 102. ESTABLISHMENT OF UPPER LIMIT

An upper limit applicable to all inpatient costs, except capital costs and professional component costs, shall be set at the weighted median cost for hospitals in each peer group, with the exception of hospitals serving a disproportionate number of indigent patients. (See Section 102B regarding hospitals determined to meet disproportionate share requirements).

Rehabilitation hospitals and acute care hospitals providing only rehabilitation services shall be exempted from operating upper limits.

General procedures for setting the upper limit shall utilize cost reports available as of November 1 of each year for all hospitals, allowable Medicaid inpatient cost, excluding those fixed costs associated with capital expenses, and professional component cost shall be trended to the beginning of the prospective rate year. The trending factor shall be established using the Date Resources, Inc., average rate of inflation applicable to the period being trended. The trending factor thus determined shall be utilized to establish the allowable Medicaid inpatient cost basis for indexing.

The cost basis shall then be indexed for the prospective rate year to allow for projected inflation for the year. The result represents the Medicaid inpatient allowable cost basis for rate setting, which is then converted to a per diem cost

TN # 97-03 Approval Date DEC 21 2000 Effective Date 1/1/97
Supersedes
TN # 95-11

utilizing the latest available Medicaid inpatient bed day statistics for each hospital.

For purposes of applying an upper limit, hospitals shall be peer grouped according to licensed bed size. The peer groupings for this payment system shall be as follows: 0-50 beds,51-100 beds,101-200 beds, 201-400 beds, and 401 beds and up.

The hospital inpatient operating cost per diems shall be arrayed from lowest to highest by peer group. Hospitals exempted from operating limits shall not be included in the array(s). Newly constructed hospitals and newly participating hospitals shall be excluded from the arrays until a cost report that contains twelve (12) full months of data is available. The median cost per diem for each of the five (5) arrays shall be based on the median number of patient days. The upper limit for each peer group containing facilities with more than 100 beds shall be computed at the median. The upper limit for each peer group of facilities with less than 101 beds shall be 110 percent of the weighted median. The upper limit for state designated teaching hospitals shall be established at 106 percent of the weighted median per diem for hospitals in their peer group. State teaching hospitals owned or operated by the University of Kentucky and

the University of Louisville hospitals shall be removed from the array in order to set the upper limit for other hospitals in the class. These state teaching hospitals shall be subject to the upper limits for facilities with 401 beds and up

Psychiatric hospitals shall not be peer grouped, but shall be in a separate array of psychiatric hospitals only.

Except as indicated in Section 101, the operating cost per diem and the capital cost per diem shall be limited to the prior year's rate per diem increased by 150 percent of the DRI average rate of inflation.

Section 102A. PAYMENT FOR CHILDREN WITH EXCEPTIONALLY HIGH COST OR LONG LENGTHS OF STAY

(a). CHILDREN UNDER AGE ONE (1)

For medically necessary hospital inpatient services provided to infants under the age of one (1) with exceptionally high cost or long lengths of stay, the payment shall be the same as item (b) of this section. These payments shall apply without regard to length of stay or number of admissions of the infants and regardless of whether they are in a disproportionate share hospital.

(b) CHILDREN UNDER AGE SIX (6) IN A DISPROPORTIONATE SHARE HOSPITAL

For medically necessary stays in disproportionate share hospitals, the allowable length of stay for children under age six (6) shall not be limited. After thirty (30) days from the date of admission (thirty (30) days from the date of the mother's discharge in the case of newborns), the facility shall be paid a per diem equal to 110 percent of their normal per diem. During the initial thirty (30) days the hospital shall be paid its normal per diem. The payment rate shall be based on the hospital's prospective rate in effect for the period billed.

Section 102B. DISPROPORTIONATE SHARE HOSPITALS

42 U.S.C. 1396r-4, as amended, imposed new requirements regarding payments to hospitals considered to be serving a disproportionate share of indigent individuals (i.e., the term "disproportionate share hospital"). This section of the manual specifies which hospitals shall be classified as disproportionate share, and the payment adjustment made with regard to them.

(a) Classification

(1) Disproportionate share hospitals shall be defined as those hospitals meeting the following criteria:

A. The hospital shall have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid eligible individuals. If the hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

B. Item A above shall not apply to a hospital if:

1. The inpatients are predominately individuals under eighteen (18) years of age; or

2. The hospital did not offer nonemergency obstetric services as of December 21, 1987.

C. In addition to the criteria in (A) and (B) of this section, the hospital shall have a Medicaid inpatient utilization rate of not less than one (1) percent to be considered as disproportionate share.

(b) The following upper limits and payment principles shall apply to disproportionate share hospitals:

(1) Acute care hospitals with Medicaid utilization of twenty (20) percent or higher, or having twenty-five (25) percent or more nursery days resulting from Medicaid covered deliveries as compared to the total number of allowable Medicaid days, shall have an upper limit set at 120 percent of the weighted median per diem cost for hospitals in the array. In addition

SECTION 102B. DISPROPORTIONATE SHARE HOSPITALS

(2) State university teaching hospitals having Medicaid utilization of twenty (20) percent or higher, or having twenty-five (25) percent or more nursery days resulting from Medicaid covered deliveries as compared to the total number of paid Medicaid days shall have an upper limit set at 126 percent of the weighted median per diem cost for hospitals of 401 beds or more. Any state designated pediatric teaching hospitals shall also be paid, in addition to the facilities' base rate, an amount which is equal to two (2) percent of the rate for each one (1) percent of Medicaid occupancy but this amount shall not exceed the prospective, reasonably determined uncompensated Medicaid cost to the facility. For the rate year ending June 30, 1999, any state designated state pediatric hospital further meeting the qualifications of a Type III hospital, instead of the above, shall be paid a supplemental payment in an amount equal to two (2) percent of the rate for each one (1) percent of Medicaid occupancy but this amount shall not exceed the Medicaid charges of the hospital. In addition to the per diem amount computed using the limits specified in this paragraph, the hospitals shall be paid, if appropriate, additional amounts for services to infants under age six (6) (as shown in Section 102A).

TN# 99-03
Supersedes TN# 97-03 Deemed Approval Date MAR 0 2 2001 Effective Date 4/1/99

(3) Psychiatric hospitals with Medicaid utilization of thirty-five (35) percent or higher shall have an upper limit set at 115 percent of the weighted median per diem cost for psychiatric hospitals in the array.

(4) All other disproportionate share acute care hospitals shall have their upper limit set at the weighted median per diem of the cost for hospitals in the array. In addition to the per diem amount computed in this manner, the hospitals shall be paid, if appropriate, an additional amount for services to infants under age six (6) (as shown in Section 102A).

A. Frequency of Review

Except as otherwise specified in this paragraph, classification of disproportionate share hospitals shall be made prospectively prior to the beginning of each universal rate year. Classification, once determined by the department, shall not be revised for that rate year except that for psychiatric hospitals not previously determined to meet disproportionate share hospital status due to failure to meet the one (1) percent minimum Medicaid occupancy requirement, the department shall also accept no more frequently than once each calendar year a patient census submitted by the

hospital showing adequate Medicaid occupancy with the subsequent classification to be effective for the balance of the calendar year.

(d) Disproportionate share hospital types shall be as follows:

(1) Type I hospitals shall be those in-state disproportionate share with 100 beds or less participating in the Medicaid program.

(2) Type II hospitals shall be those in-state disproportionate share hospitals with 101 beds or more, except for Type III and IV, participating in the Medicaid program.

(3) Type III hospitals shall be those in-state disproportionate share hospitals participating in the Medicaid program that have been designated as State university teaching hospitals and have made a request to the Department for Medicaid Services to be designated as a Type III hospital with the request subsequently approved by the department. As part of its designation as a Type III hospital, the hospital shall agree to provide up to 100 percent of the state's share of matching funds necessary to secure federal financial participation for Medicaid disproportionate share hospital payments to be made to the hospital during the period of time the hospital is classed as a Type III hospital;

(4) Type IV hospitals shall be those in-state disproportionate share hospitals participating in the Medicaid Program that are state-owned psychiatric hospitals.

(5) Type V hospitals shall be those out-of-state disproportionate share hospitals participating in the Medicaid program.

Section 102C. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

(a) The disproportionate share hospital payments for Type I and Type II hospitals shall be based on the cost of providing indigent care. Total disproportionate share payments to Type I and Type II hospitals for indigent care services provided during the 1997 fiscal year shall not exceed available funds; if payments cause the limits to be exceeded, all hospitals shall be adjusted proportionately. The funds shall be distributed to each qualifying hospital according to its proportion of costs to the total funds available for the year. The proportions shall be calculated by dividing the cost of each hospital's indigent care by the total cost of indigent care for all hospitals.

(b) The disproportionate share hospital payments for Type III hospitals and Type IV hospitals shall be equal to 100 percent of the cost of providing services to Medicaid patients, less the amount paid by Medicaid as usual Medicaid per diem payments, plus the cost of services to uninsured patients, less any cash payments made by the uninsured patients.

TN # 97-03
Supersedes
TN# 95-11

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(c) The disproportionate share hospital payments for Type V hospitals shall be one (1) dollar per Medicaid day plus an earned adjustment which is equal to ten (10) cents for each one (1) percent of Medicaid occupancy above one (1) standard deviation.

TN # 97-03
Supersedes
TN# 95-11

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Section 102D. PROVIDER TAXES

Provider taxes shall be considered an allowable cost with that portion attributable to Medicaid utilization included in the per diem rates.

Section 103. INFLATION FACTOR

After allowable costs have been trended to the beginning of the rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.

The inflation factor index to be used in the determination of the prospective rate shall be the inflation factor prepared by Data Resources Inc., forecasting in conjunction with relative weights developed by the Health Care Financing Administration (HCFA). The forecasted index represents the average inflation rate for the year and shall have general applicability to all participating hospitals.

The forecasted index utilized by the program shall remain in effect for the prospective rate year.

Adjustments shall not be made to the prospective rate if actual inflation differs from the projected inflation index.

Section 104. NEW PROVIDERS, CHANGE OF OWNERSHIP:

(a) CHANGE OF OWNERSHIP.

If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the prospective rate in effect. The new owner may appeal its rate subject to the provisions of Section 113. If at the time of the next prospective rate setting, the hospital does not have twelve (12) full months of actual costs in the fiscal year for which the cost report is submitted, the department shall use a partial fiscal year cost report to arrive at a prospective rate. This cost will be annualized and indexed appropriately.

(b) NEWLY CONSTRUCTED OR NEWLY PARTICIPATING HOSPITALS

Until a fiscal year end cost report is available, newly constructed or newly participating hospitals shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification. A prospective rate shall be set based on this data, not to exceed the upper limit for the class. This prospective rate shall be tentative and subject to settlement at the time the first audited fiscal year end report is received from the Medicare intermediary. During the projected rate year, the budget can be adjusted if indicated, and justified

by the submittal of additional information.

(c) MERGED FACILITIES

In the case of two (2) separate entities that merge into one (1) organization, the Department for Medicaid Services shall merge the latest available data used for rate setting. Bed utilization statistics shall be combined, creating new occupancy ratios. Costs shall also be combined using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs. The rate of increase control (RIC) applicable to each entity shall be computed on a weighted average, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting. If one (1) of the entities merging has disproportionate status and the other does not, the merged entity shall retain the status of the entity which reported the highest number of Medicaid days paid. These merged per diem rates shall be subject to an appeals process. Finally, each provider shall submit a "Close of Business" Medicaid cost report for the period ended as of the day before the merger. This report shall be due from the provider within the time frame outlined in Section 109 of this manual. Medicaid cost reports for the period starting with the day of the merger and ending on

the day before the merger. This report shall be due from the provider within the time frame outlined in Section 109 of this manual. Medicaid cost reports for the period starting with the day of the merger and ending on the fiscal year end of the merged entity shall also be filed with the department in accordance with Section 109 of this manual.

Section 105. MINIMUM OCCUPANCY FACTOR

To assure that only program costs are compensated under this payment system and to encourage maximum occupancy, a minimum occupancy level shall be applied to Medicaid inpatient capital costs attributed to the program based on licensed beds available during the prior year.

(a) Hospitals with 100 or less licensed beds shall have a minimum occupancy factor of sixty (60) percent applied.

(b) Hospitals with 101 or more licensed beds shall have an occupancy factor of seventy-five (75) percent applied.

(c) Newly constructed hospitals shall be allowed one (1) full rate year before the minimum occupancy factor shall be applied.

Section 106. UNALLOWABLE COSTS

(a) The following costs shall not be considered allowable costs for Medicaid reimbursement:

(1) Costs associated with political contributions.

(2) The cost associated with legal fees for unsuccessful lawsuits against the cabinet. Legal fees relating to lawsuits against the cabinet shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and

(3) The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities. However, costs (excluding transportation costs) for training or education purposes outside the Commonwealth of Kentucky shall be allowable costs. If these meetings are not educational, the cost (excluding transportation) shall be allowable if educational or training components are included.

(b) Since the costs in the referenced Section are currently not identified by the Medicare or Medicaid cost report, hospitals shall identify these unallowable costs on the Supplemental Medicaid Schedule KMAP-1. The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report. The purpose of the Supplemental Medicaid Schedule KMAP-1 is to identify these unallowable costs for exclusion from the prospective rate computation.

Section 107. TRANSPLANTS

The program shall reimburse hospitals for transplants at the lessor of 80% of covered charges or a flat fee not to exceed $75,000. An exception to this limit may be made by the Commissioner, Department for Medicaid Services, on a case-by-case basis when the maximum payment limit restricts or prohibits the availability of the needed transplant procedure or service.

The costs associated with transplants shall not be included in allowable Medicaid costs. The charges and costs shall be reported in the total hospital charges and total hospital costs but shall not be included in the Medicaid charges or payments.

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TN # 95-11

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Section 108. RETROACTIVE SETTLEMENTS

Revision of the prospective payment rate shall be made under the following circumstances:

(a) If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data shall not constitute a computational error.

(b) If a determination of misrepresentation on the part of the facility is made by the program.

(c) If unaudited data is utilized to establish the universal rate, the rate shall be revised when the audited cost report is received from the fiscal intermediary or an independent audit firm under contract with the Department for Medicaid Services. If circumstances (a) or (b) occur, a settlement or revision shall be made only after the audited cost report is received from the fiscal intermediary. Factors which may affect the cost basis are costs utilized in determining Medicaid capital costs, i.e., total inpatient cost and total capital cost, and Medicaid allowable costs.

In accordance with Medicaid regulations at 42 CFR 447.271, Medicaid payments for inpatient hospital services shall be adjusted for the lesser of

total prospective payments or customary charges at the end of the prospective rate year. There shall be no allowance made under the prospective system for the carry forward provision utilized by Medicare (Title XVIII) in regard to the lesser of prospective payments or customary charges for inpatient services.

Section 109. COST REPORTING REQUIREMENTS

Each hospital participating in the Kentucky Medicaid Program shall submit an annual cost report, (HCFA 2552) including the Supplemental Medicaid Schedules, in the manner prescribed by the Medicaid Program. The cost report shall be submitted within five (5) months after the close of the fiscal year. An extension shall not be granted by the Medicaid Program. If the filing date lapses, the Program shall then suspend all payments to the facility until an acceptable cost report is received. The reports shall be filed for the fiscal year used by the facility.

Section 110. ACCESS TO SUBCONTRACTOR'S RECORDS

If the hospital has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for services costing or valued at $10,000 or more over a twelve (12) month period, the contract shall contain a clause giving the department access to the subcontractor's books. Access shall also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor.

Section 111. AUDIT FUNCTION

After the hospital has submitted the annual cost report, the program shall perform a limited desk review. The purpose of a desk review is to verify prior year cost to be used in setting the prospective rate. The Medicare intermediary shall be informed of any findings as a result of this desk review. Under a common audit agreement, the Medicare intermediary provides Medicaid with copies of any audits performed by Medicare (Title XVIII) and Medicaid (Title XIX) purposes. However, the program may choose to audit even though Medicare does not.

Section 112. DUAL LICENSED AND SWING BEDS

(a) DUAL LICENSED BEDS

Effective January 1, 1997, the department shall no longer reimbursedual licensed beds in hospitals.

(b) SWING BEDS

Federally defined swing beds shall be reimbursed by the program at the weighted average payment rate for routine services for the prior calendar year for all nursing facilities (excluding intermediate care facilities for the mentally retarded and developmentally disabled) in the state, depending on the level of care requirements of the patient in the swing bed.

(c) ANCILLARY SERVICES FOR DUAL LICENSED AND SWING BEDS

Payments for reimbursable ancillary services provided to nursing patients in dual licensed or swing beds shall be based on a facility-specific cost-to-charge ratio with a settlement to actual cost at the end of the facility's fiscal year. Ancillary services covered shall be the same ancillary services as are covered in the regular nursing care setting.

At the end of each facility's fiscal year a KMAP-2 and a KMAP-3

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shall be filed with the cost report. The Medicaid Program shall make a final settlement on the ancillary services provided to patients in dual licensed beds. A separate KMAP-2 and KMAP-3 should be completed for each level of care. For swing bed, the usual Medicare cost report forms shall be completed.

Section 113. REIMBURSEMENT REVIEW APPEAL PROCESS

A. Pursuant to 42 CFR 447.253(e), the department provides the following appeals procedure for a review of an individual hospital's rate limited to the following:

1. Increased costs related to allowable inpatient cost centers resulting from a capital expenditure requiring a certificate of need;

2. Increased costs related to allowable inpatient cost centers resulting from a capital expenditure not requiring a certificate of need meeting a qualifying determining amount of at least twenty-five (25) percent of its total fixed assets as reported on Worksheet G, Line 21 of its base year Medicare cost report; and

3. A mathematical or clerical error by the department.

B. The costs that represent the subject matter of an appeal shall increase the current per diem rate by at least five (5) percent in order for any relief to be granted.

C. A request for an administrative appeal under this section shall be in accordance with the following:

1. The certificate of need for the equipment that is the subject matter of the appeal must have been placed in service during the state fiscal year immediately preceding the rate year under appeal.

2. The following shall be included in the appeal request by the provider:

a. Documentation that demonstrates that the costs related to the certificate of need have not been built into the rate;

b. Operating and capital costs related to certificate of need for capital expenditure or capital costs related to a capital expenditure not requiring a certificate of need provided on a per diem basis as follows:

1.) For a capital expenditure not requiring a certificate of need and used for the provision of inpatient services only, the total costs of the capital expenditure shall be divided by total allowable patient days to determine the *costs per day*.

2.) For a capital expenditure requiring a certificate of need and used for the provision of inpatient services only, the total costs of the capital expenditure shall be divided by total allowable patient days to determine the *costs per day*.

3.) For a capital expenditure not requiring a certificate of need and for a capital expenditure requiring a certificate of need, that shall be used for inpatient and outpatient hospital services, the per diem costs shall be calculated by adjusting for outpatient utilization through an adjusted patient day calculation as follows:

a.) Total allowable inpatient revenues shall be divided by total allowable inpatient days to determine the *inpatient revenue per day*;

b.) Total outpatient revenues shall be divided by inpatient revenue per day to determine *outpatient equivalent days*;

c.) Inpatient days and outpatient equivalent days determined in accordance with 3.a. and 3.b. of this section shall be added to determine *adjusted patient days*; and

d.) Adjusted patient days shall be divided by total costs to determine *costs per day*.

3. Total patient days shall be the total patient days submitted on the base year Medicare cost report on Worksheet S-3, Column 6, excluding nonallowable cost centers.

4. Total inpatient revenue shall be the total inpatient revenue submitted on the base year Medicare cost report on Worksheet G-2, Column 1, Line 25, less nonallowable cost centers.

5. Total outpatient revenue shall be the total outpatient revenue submitted on the base year Medicare cost report on Worksheet G-2, Column 2, Line 25, less nonallowable cost centers.

6. Operating costs shall include salaries associated with additional full time equivalents (FTE) added as a result of the certificate of need.

7. Costs calculated in accordance with 2b. of this section shall be the only adjustments to be considered by the department to the applicable operating and capital components of a hospital's per diem rate.

8. The department shall adjust any relief granted under this section to the extent the relief is based on unaudited data, once the department is in possession of final audited data.

Section 114. PSYCHIATRIC HOSPITALS SUPPLEMENTS

Psychiatric hospitals shall be reimbursed in accordance with this reimbursement manual for hospital inpatient services, except as specified in this supplemental section.

(a) MAXIMUM PAYMENT

The upper limit shall be established at the weighted median of the array of allowable costs for all participating psychiatric hospitals, except that disproportionate share hospitals, as defined in this Section, shall have a payment rate calculated in accordance with Section 102A.

(b) DISPROPORTIONATE SHARE HOSPITALS

Psychiatric hospitals which qualify as disproportionate share hospitals are classified, as appropriate, as the various types shown in Section 102C of this manual.

(c) MEDICAID UTILIZATION

Hospitals having a Medicaid utilization of thirty-five (35) percent or

higher shall have an upper limit established at one-hundred and fifteen (115) percent of the weighted median.

(d) OCCUPANCY FACTOR

A minimum occupancy level will be imposed relative to Medicaid inpatient capital cost as outlined in Section 105.

(e) DEPRECIATION

Medicaid inpatient capital costs will be based on Medicare cost finding principles including full allowance for depreciation cost.

(f) CONTRACTUAL INPATIENT SERVICES

A psychiatric hospital designated by the cabinet as a primary referral and services resource for children in the custody of the Cabinet for Families and Children shall be exempt from the upper limit for the array and shall be paid at the actual projected cost with no year end settlement to actual cost; the projected cost may be adjusted for usual DRI cost of living increases.

Section 115. HOSPITAL INDIGENT CARE REPORTING REQUIREMENTS

All hospitals shall report monthly data on a quarterly basis the care provided to indigent individuals and families as defined in state law, including care provided to indigent persons age twenty-two (22) to sixty-four (64) in a psychiatric hospital, excluding nonemergency care provided through a hospital emergency room.

Section 116. DEFINITIONS

The following terms are used throughout the manual and are defined in the following context.

(a) Allowable inpatient operating cost per diem – the allowable inpatient operating cost computed as a per diem amount after exclusion of unallowable operating costs and applications of upper limits.

(b) Base rate – The sum of the allowable inpatient operating cost per diem, the allowable capital cost per diem, and the allowable professional component cost per diem.

(c) Base year – The base year is the facility's fiscal year used for setting a rate. Under this system, payment to hospitals is determined prospectively by establishing a base year cost for the hospital. The base year cost for the hospital is the latest available Medicaid cost report data trended to the beginning of the universal rate year using the Data Resources, Inc. trend factor.

(d) Cost basis – Cost basis refers to the total allowable Medicaid inpatient costs incurred by the provider in the base year.

(e) Universal rate year – The universal rate year, under the prospective payment system is the year beginning January 1 for which payment rates are established for all hospitals for a calendar year regardless of the hospital's fiscal year end.

(f) University teaching hospital – A hospital is designated to be a university teaching hospital is owned or operated by a university with a medical school.

(g) Low income utilization rate – For a hospital, the sum (expressed as a percentage) of the fraction, calculated as follows:

(1) Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of the cash subsidies) in the same cost reporting period; and

(2) The total amount of the hospital's charges for inpatient services attributable to charity care (care provided for individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies for patient

services received directly from the State and local governments in the period attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross, etc.

Section 117. SUPPLEMENTAL MEDICAID SCHEDULES AND INSTRUCTIONS

This section contains the supplemental Medicaid schedules and instructions used for hospital rate setting purposes.

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INSTRUCTIONS FOR SUPPLEMENTAL MEDICAID SCHEDULE

KMAP-1

NOTE: FOR HCFA-2552-92 (11-92)

ine 1 – Enter amount paid as legal fees associated with lawsuits brought against the Cabinet for Human Resources. (See " Medicaid Reimbursement Manual for Hospital Inpatient Services", Section 106(a)(2).

ine 2 – Enter all expenses associated with political contributions.

ine 3 – Enter all expenses associated with travel outside the Commonwealth.

ine 4 – Sum of lines 1, 2, and 3.

olumn 3 Enter amounts from HCFA-2552-92, Worksheet B, Part I, Column 25 on the appropriate lines, as indicated. Note that Line 11A and 11B are taken from Worksheet D-2 as indicated, and the total of these two should equal the amount of Worksheet B, Part I, Line 70.

Line 13 – Enter sum of lines 5 through 12.

Line 14 – Enter amount from line 4.

Line 15 – Divide the non-allowable cost on line 14 by the total cost on line 13 and enter answer.

olumn 4 Lines 5 through 12. Multiply the ratio from line 15 by each amount entered on lines 5 through 12 and enter answers on the appropriate line of column 4.

Line 13 – Enter sum of line 5 through 12. Sum in column 4, line 13 should equal the non-allowable cost on Line 4.

Line 16 – Enter only the sum of Lines 5A, 6, and 10A. Line 5B should only be included if the cost is applicable to a psychiatric or rehabilitation unit.

Line 17 – Divide the Medicaid Inpatient Allowable Cost (HCFA-2552-92, 11/92, Worksheet E-3, Part III, Total of Lines 1 through 5 plus 5A) by the Total Inpatient Allowable Cost (HCFA-2552-92), Worksheet B, Part I, Column 25. Total expenses less amounts on Line 60 through to total expenses with exception of Line 70 which should be included in Total Inpatient Allowable Cost.

Line 18 – Multiply the amount entered on Line 16 by the ratio on Line 17 to determine the Medicaid portion of the non-allowable cost.

Line 19 – Deduct the amount entered on Line 18 from the Medicaid Inpatient Allowable Cost (HCFA-2552-92, Worksheet E-3, Part III, Line 6).

Line 20 – Enter only the sum of the amount of non-allowable cost from Lines 7 and 10B.

Line 21 – Divide Medicaid Outpatient Allowable Cost (HCFA-2552-92, Worksheet E-3, Part III, Column 2, Line 6) by the Total Outpatient Allowable Cost (HCFA-2552-92) Worksheet B, Part I, Column 25, Lines 60 through 63.

Line 22 – Multiply the ratio from Line 21 by the amount from Line 20.

Line 23 – Deduct the amount on Line 22 from the amount entered on Worksheet E-3, Part III, Column 2, Line 6.

SUPPLEMENTAL MEDICAID SCHEDULE I

Computation of Legal Fees, Political Contributions, and Out-of-State travel not Allowable to Medicaid Services

Legal Fees _____
Political Contributions _____
Out-of-State Travel _____
Total Non-Allowable Cost _____

HOSPITAL _____
VENDOR NO _____
PERIOD FROM _____
PERIOD TO _____

Column 1	Column 2	Column 3	Column 4
COST CENTERS	From Medicare Cost report Worksheet B	Accumulated Cost	Allocated Non-Allowable Costs
Inpatient routine Service A. Hospital	Total of Lns. 25-30 & 33		
B. Sub Providers (other than Inpatient Hospital)	Lns. 31,32, 34-36		
Ancillary Service Cost Center	Total of Lines 37-59		
Outpatient Service Cost Centers	Tot Lns. 60-63		
Home Program Dialysis	Ln. 64		
Ambulance Services	Ln. 65		
)A. Intern-Res. Srvc. Not Appr. (I/P) D-2, Ln. 19, Col. 2*	Ln. 70		
)B. Intern-Res. Srvc. Not Appr. (O/P) D-2, Line 23, Col. 2*			
l. Other Cost Centers	Ln. 71-94		
2. Non-Reimbursable Cost Centers	Tot. Lns. 96-103		
1. Total Expenses (Sum of Lns. 5-12)			
4. Total Non-Allowable Costs (Line 4)			
5. Unit Cost Multiplier (Ln. 14 / Ln. 13)			
6. Non-Allowable Cost Applicable to Inpt. Costs			
7. Medicaid Inpatient Allowable Cost (Supplemental Worksheet E-3, Part III. Total of Lns. 1 thru 6 plus 7b, excluding all outpt.) divided by the total Inpt. allowable hospital cost (Worksheet B, Part I) See Instructions Attached			
8. Medicaid Non-Allowable Cost Line 16 X Line 17			
9. Medicaid Allowable Cost. Deduct the amount entered on Line 18 from the Medicaid Services Inpatient Cost on E-3 Part III, Col 1, Line 6			
OUTPATIENT			
0. Non-Allowable cost applicable to outpatient cost from line 7 and 10B.			
1. Determination of Medicaid Non-allowable Cost. (See Instructions Attached)			
2. Medicaid Non-Allowable Outpatient Cost. (Line 20 X Line 21)			
3. Medicaid Allowable Outpatient Cost. Deduct the amount entered on Line 22 from the Medicaid Services Outpatient Cost on E-3 Part III Col 2 Line 6			

Costs are broken between Inpatient and Outpatient Departments on W/sheet D-2

State Kentucky

COMPUTATION OF DUAL LICENSED ANCILLARY COST

HOSPITAL VENDOR NUMBER _____

ICF DUAL LICENSED PROVIDER NUMBER _____
SNF DUAL LICENSED PROVIDER NUMBER

ANCILLARY COST CENTERS	TOTAL ANC. COST COL. 1	TOTAL DIRECT COST COL. 2	DIRECT COST % COL.3 (2/1)	TOTAL INDIR. COST COL. 4	INDIR. COST % COL. 5 (4/1)	RATIO OF COST TO CHG COL.6	DIRECT COST TO CHG RATIO COL. 7 (6X3)	MEDICAID DUAL INPATIENT CHARGES (BILLED) COL. 8	INPATIENT DIRECT COST COL. 9 (7X8)	INDIRECT COST TO CHG. RATIO COL. 10 (6 X 5)	MEDICAID DUAL CHARGE (BILLABLE & NON-BILLABLE UNDER SNF) COL. 11	INPATIENT INDIRECT COST COL. 12 (10 X 11)
41 RADIOLOGY-DIAGNOSTIC												
42 RADIOLOGY-THERAPEUTIC												
43 RADIOISOTOPE												
44 LABORATORY												
45 PBP CLINIC LAB SVC-PRG. ONLY												
46 WHOLE BL. & PK. RED BL. CELLS												
48 IV THERAPY												
49 RESPIRATORY THERAPY												
51 OCCUPATIONAL THERAPY												
53 ELECTROCARDIOLOGY												
54 ELECTROENCEPHALOGRAPHY												
55 MED. SUPPLIES CHG. TO PT.												
56 * DRUGS CHARGED TO PATIENTS												
101 TOTAL												

104 AMOUNT RECEIVED FROM THE MEDICAID PROGRAM (FROM PROGRAM PAID CLAIMS LISTING)

105. AMOUNT DUE PROGRAM/PROVIDER (LINE 101, COL. 9 LESS LINE 104)

INSTRUCTIONS

1. TOTAL ANCILLARY COSTS FROM HCFA-2552-89, WORKSHEET C, COLUMN 3
2. ALL COST ALLOWABLE UNDER MEDICAID IC/SNF RULES AS DIRECT COST
3. COLUMN 2 DIVIDED BY COLUMN 1
4. ALL OTHER ANCILLARY COST (COLUMN 1 LESS COLUMN 2)
5. COLUMN 4 DIVIDED BY COLUMN 1
6. RATIO OF COST TO CHARGES FROM HCFA-2552-92, WORKSHEET C, COL. 8
7. COLUMN 6 MULTIPLIED BY COLUMN 3
8. DUAL LICENSED CHARGES BILLED TO THE MEDICAID PROGRAM
9. COLUMN 7 MULTIPLIED BY COLUMN 8
10. COLUMN 6 MULTIPLIED BY COLUMN 5
11. ALL DUAL LICENSE CHARGES INCLUDING THOSE CHARGES BILLABLE AND NON-BILLABLE TO THE MEDICAID IC/SNF PROGRAM. SHOULD NOT INCLUDE THOSE CHARGES CONSIDERED TO BE NON-ALLOWABLE COST FOR SERVICES IN A LONG TERM CARE SETTING
12. COLUMN 10 MU[illegible]PLIED BY COLUMN 11. TRANSFER THIS AMOUNT TO KMAP-3, LINE 13

* COST AND C[illegible]GES PRIOR TO OCTOBER 1, 1990 ONLY

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KMAP-3

SUPPLEMENTAL MEDICAID SCHEDULE

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR DUAL LICENSED BEDS

HOSPITAL _____

VENDOR # _____

PERIOD FROM _____ PERIOD TO _____

1.	Dual-licensed NF-type Medicaid inpatient days	
2.	Dual-licensed SNF-type Medicaid inpatient days	
3.	Dual-licensed ICF-type Medicaid inpatient days	
4.	Medicaid rate for dual-licensed NF bed services	
5.	Medicaid rate for dual-licensed SNF bed services	
6.	Medicaid rate for dual-licensed ICF bed services	
7.	Medicaid payments for dual-licensed NF-type services (Line 1 x Line 4)	
8.	Medicaid payments for dual-licensed SNF-type services (Line 2 x Line 5)	
9.	Medicaid payments for dual-licensed ICF-type services (Line 3 x Line 6)	
10.	Total Medicaid payments for dual-licensed services (Line 7 + Line 8 + Line 9)	
11.	Total Medicaid dual licensed inpatient routine service cost	
12.	Medicaid dual licensed inpatient routine service cost net of dual-licensed payments (Line 11 – Line 10)	
13.	Indirect cost for ancillary services rendered to dual-licensed patients	
14.	Total unreimbursed Medicaid dual license inpatient service cost (Line 12 + Line 13)	

INSTRUCTIONS

Line #

1. From the Medicaid program's Paid Claims Listings
2. From the Medicaid Program's Paid Claims Listings
3. From the Medicaid Program's Paid Claims Listings
13. Transfer from KMAP-2 Line 101, Column 12
14. Line 12 plus line 13.

* Effective for services provided after October 1, 1990

SUPPLEMENTAL MEDICAID SCHEDULE 4

FACILITY:

FYE:

VENDOR NUMBER:

a. Did your facility offer nonemergency obstetric services as of December 21, 1987? (ANSWER YES "ONLY" IF THERE WERE "AT LEAST" 2-OB'S OR PHYSICIANS WHO OFFERED NON-EMERGENCY OBSTETRIC SERVICES.)

Yes _____
No _____

b. Does your facility predominantly serve individuals under 18 years of age?

Yes _____
No _____

If yes, indicate the percent of the individuals under 18 years of age.

% _____

c. Does your facility have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medicaid eligible individuals? In the case of a hospital located in a rural area (that is an area outside a Metropolitan Statistical Area), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Yes _____
No _____

2. Enter the total Medicaid inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments.

$ _____

3 Enter the total inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments.

$ _____

4. Enter the total amount of the facility's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources).

The total inpatient charges attributed to charity care should not include bad debts or contractual allowances and discounts (other than for indigent patients not eligible for Medicaid), that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

The charges should be net of any cash subsidies for patient services received directly from state and local governments in the period attributable to inpatient hospital services.

$ _____

5 Enter the total amount of the facility's charges for inpatient services.

$ _____

The above statements are accurate and correct to the best of my knowledge.

Signed: _____
President, Administrator, or Chief Financial Officer

SUPPLEMENTAL WORKSHEET 5

(MEDICAID SERVICES DEPRECIATION)

HOSPITAL _____
VENDOR # _____
PERIOD FROM _____ PERIOD TO _____
REASON FOR REVISION _____

A. INSTRUCTIONS

B. CAPITAL COST COMPUTATION

1A. TOTAL CAPITAL COST (W/S B, PART II + B PART III COLUMN 4A – LINE 95) LESS NON-ALLOWABLE COST CENTERS) LESS INTEREST/INSURANCE/TAXES (RELATED TO CAPITAL COST W/S A-7 PART III) = ADJUSTED TOTAL CAPITAL COST.

LINE 1B. | | | |

2A. ADJUSTED TOTAL CAPITAL COST (LINE1) / TOTAL CAPITAL COST = RATIO.

LINE 2B. | | | |

3A. RATIO (LINE 2) X MEDICAID SERVICES CAPITAL COST (ROUTINE AND ANCILLARY W/S D, PARTS I AND II = ADJUSTED MEDICAID SERVICES CAPITAL COST (MEDICAID SERVICES CAPITAL COST LESS INT./INS./TAXES).

LINE 3B. | | | |

4A. TOTAL BLDG. AND FIXTURES / TOTAL CAPITAL COST = RATIO
(W/S B, PART II & B PART III COL. 1 & 3 LINE 95) LESS NON-ALLOWABLE COST CENTERS)
(W/S B PART II & B PART III 4A. LINE 95 LESS NON-ALLOWABLECOST CENTERS)
(RATIO OF BLDG. AND FIXTURES TO TOTAL CAPITAL COST).

LINE 4B. | | | |

5A. RATIO (LINE 4) X MEDICAID SERVICES ADJUSTED CAPITAL COST (LINE 3) = MEDICAID SERVICES BLDG. AND FIXTURES .

LINE 5B. | | | |

6A. MEDICAID SERVICES CAPITAL COST LESS MEDICAID SERVICES BLDG.& FIXTURES (LINE 5) = MEDICAID SERVICES MOVABLE EQUIP. AND INTEREST/ INSURANCE / TAXES.

LINE 6B. | | | |

7A. 65% X MEDICAID SERVICES BLDG .& FIX. (LINE 5) = ALLOWABLE MEDICAID SERVICES BLDG. & FIXTURES

LINE 7B. | 0.65 | | |

8A. MEDICAID SERVICES EQUIPMENT AND INTEREST/INSURANCE/TAXES (LINE 6) + MEDICAID SERVICES ALLOWABLE BLDG. & FIXTURES (LINE 7) = MEDICAID ALLOWABLE INPATIENT CAPITAL COST

Line 8B. | | | |

SUPPLEMENTAL MEDICAID SCHEDULE 6

'ROFESSIONAL COMPONENT/LABOR-DELIVERY ROOM DAYS/NURSERY INFORMATION

HOSPITAL _____
VENDOR NUMBER _____
PERIOD FROM _____
PERIOD TO _____

AUDITOR _____
DATE _____
REVIEWER _____
DATE _____

\. HOSPITAL-BASED PROFESSIONAL COMPONENT SERVICES

:OST CENTERS	Col. 1 TOTAL PROFESSIONAL COMPONENT CHG. INPATIENT	Col. 2 TOTAL MEDICAID SERVICES PROFESSIONAL COMPONENT CHG. INPATIENT	Col. 3 TOTAL PROFESSIONAL COMPONENT CHG. OUTPATIENT	COL. 4 TOTAL MEDICAID SERVICES PROFESSIONAL COMPONENT CHG OUTPATIENT
\NESTHESIOLOGY				
\ADIOLOGY-DIAGNOSTIC				
\ADIOLOGY-THERAPEUTIC				
\ADIOSOTOPE				
ABORATORY				
:KG				
:EG				
3LANK				
3LANK				
:MERGENCY ROOM				

VHEN PROFESSIONAL COMPONENT SERVICES ARE INCLUDED IN THE COST REPORT, A SUPPLEMEN-
'AL WORKSHEET D-3 SHOULD BE COMPLETED. ALSO, THIS OFFICE MUST RECEIVE THIS SUPPLEMENTAL
3CHEDULE IDENTIFYING, BY COST CENTERS, THE TOTAL PROFESSIONAL COMPONENT CHARGES
\NC : MEDICAID SERVICES PROFESSIONAL COMPONENT CHARGES.

3. LABOR/DELIVERY ROOM DAYS

)OES TOTAL HOSPITAL ADULT AND PEDIATRIC DAYS (EXCLUDING SWING BEDS) ON WORKSHEET
3-3 (HOSPITAL STATISTICAL DATA) LINE 1.01, COLUMN 6 INCLUDE LABOR/DELIVERY ROOM
lays.

YES _____ NO _____

F NO, PLEASE INDICATE TOTAL LABOR/DELIVERY ROOM DAYS. _____

2. NURSERY DAYS

PLEASE INDICATE THE FOLLOWING:

1. THE NUMBER OF MEDICAID NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. _____

2. THE NUMBER OF MEDICAID NURSERY DAYS ON WORKSHEET S-3, COLUMN 5 THAT ARE ZERO PAID. _____

3. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. _____

4. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE ZERO PAID. _____

SUPPLEMENTAL MEDICAID SCHEDULE 8

COMPUTATION OF EXCLUDED ALLOWABLE

PROFESSIONAL COST WHICH IS NOT REIMBURSABLE

BY MEDICAID SERVICES ON WORKSHEET D-3

AC. _____

ENDOR #: _____ PERIOD FROM _____ PERIOD TO _____

COL. 1 Cost Centers	COL. 2 Cost From Wk/S A-8 or A-8-2
. CRNA	
. Physical Therapist	
. Respiratory Therapist	
. Clinic	
. Other	
. Total	

. Determine a ratio of Hospital Inpatient Cost to total Hospital Cost _____

. Determine a ratio of Hospital Outpatient Cost to total Hospital Cost _____

. Multiply the ratio from Line 7 & Line 8 by the total amount entered on line 6 to determine the cost applicable to Inpatient and Outpatient services.
   a. Inpatient Cost (Excluded Allowable Professional Cost) _____
   b. Outpatient Cost (Excluded Allowable Professional Cost) _____

0. . mine the ratio of Medicaid Services Inpatient Cost to total Inpatient Cost _____

1. Determine the ratio of Medicaid Services Outpatient Cost to total Outpatient Cost _____

2. Multiply the ratio of Medicaid Services Inpatient Cost Line 10 by the amount entered on line 9a for Medicaid Services Inpatient Cost. Enter the amount on Wkst. E-3 Part III, Line 5a, Col. 1. _____

3. Multiply the ratio of Medicaid Services Outpatient Cost Line 11 by the amount entered on line 9b for Medicaid Services Outpatient Cost. Enter the amount on Wkst. E-3 Part III, Line 5a, Col.2. _____

INSTRUCTIONS

LINE #

7. Divide the sum of Worksheet B, Part I, col. 25, lines 25 through 33, lines 37 through 59, and line 70 by the sum of Worksheet B, Part I, col. 25, line 103.

8. Divide the sum of Worksheet B, Part I, col. 25, lines 60 through 63 by the sum of Worksheet B, Part I, col. 25, line 103.

10. Divide the amount of Medicaid Services Inpatient cost (HCFA 2552-92,11/92, E-3, Part III, Col. 1 Total of lines 1 through 5) by the Total Hospital Inpatient Cost (Sum of Worksheet B, Part I, col. 25 lines 25 through 33, lines 37 through 59, and line 70).

11. Divide the amount of Medicaid Services Outpatient cost (HCFA 2552-9292, 11/92, E-3 Part III, Col. 2 Total of lines 1 through 5 PLUS LAB COST (D PART V) by the Total Hospital Outpatient Cost (Sum of Worksheet B, Part I col. 25, lines 60 through 63).

Methods and Standards for Establishing Payment Rates – Other Types of Care

I. Drugs

A. Reimbursement

1. Participating pharmacies are reimbursed for the cost of the drug plus a dispensing fee. Payments shall not exceed the upper limits specified in 42 CFR 447.331 through 447.334

2. Participating dispensing physicians are reimbursed for the cost of the drug only.

3. Providers will be reimbursed only for drugs supplied from pharmaceutical manufacturers who have signed a rebate agreement unless the Department has determined that it is in the best interest of Medicaid recipients to make payment for non-rebated drugs.

B. Payment Limits – Payment for the cost of drugs shall be the lesser of:

1. The Federal Maximum Allowable Cost (FMAC) of the drug for multiple source drugs other than those brand name drugs for which a prescriber has certified in writing as "brand medically necessary" or "brand necessary";

2. The Estimated Acquisition Cost (EAC) of the drug that has been established by the Department to be equal to the average wholesale price (AWP) minus twelve (12) percent ; or,

3. The provider's usual and customary charge.

Methods and Standards for Establishing Payment Rates – Other Types of Care

C. Dispensing Fee

1. The Department established dispensing fees based upon the conclusions of an annual dispensing fee study, which is required by state law. The current dispensing fee is $4.51. The dispensing fee is applied to outpatient pharmacies and to long term care facilities.

   For nursing facility residents meeting Medicaid patient status an add-on of two (2) cents per unit dose for unit dose drugs packaged in unit dose form by the manufacturer and four (4) cents per unit dose for unit dose drugs packaged in unit dose form by the pharmacists, shall be permitted.

2. The fee amount is based on a survey of pharmacy dispensing costs in the Commonwealth of Kentucky, a review of academic literature, and the reimbursement rates of other payers. The dispensing fee established will reimburse the reasonable costs of dispensing prescription drugs incurred by pharmacies in the aggregate.

1. For nursing facility residents meeting Medicaid patient status criteria, there shall be no more than one (1) dispensing fee allowed per drug within a calendar month for maintenance drugs (as determined by the Medicaid agency) and no more than two (2) dispensing fees allowed per drug within a calendar month for other drugs, except for Schedules II, III, and IV controlled substances and for non-solid dosage forms, including topical medication preparations, for which no more than four (4) dispensing fees per drug shall be paid within a calendar month. For nursing facility residents not meeting Medicaid patient status criteria and non-residents of nursing facilities, there shall be no more than one (1) dispensing fee allowed per drug per calendar month for drugs classified by the Medicaid program as maintenance drugs and no more than four (4) dispensing fees shall be allowed per drug within a calendar month for legend intravenous drugs. (Though dispensing fees are limited, this shall not be construed as placing a limit on the quantity of reimbursable drugs for which the program will pay for any patient, since the reasonable cost of the drug (as defined herein) is reimbursable as a covered service in whatever quantity is considered medically necessary for the patient. Non-solid dosage forms include all covered drug items other than oral tablets or capsule forms.)

2. For nursing facility residents meeting Medicaid patient status criteria, an addition to the usual dispensing fee of five (5) dollars and seventy-five (75) cents shall be made for drugs dispensed through the pharmacy outpatient drug program in the amount of two (2) cents per unit dose for unit dose drugs packaged in unit dose form by the manufacturer and four (4) cents per unit dose for unit dose drugs packaged in unit dose form by the pharmacist.

D. Reevaluation of Professional Fee

The professional (dispensing) fee is reevaluated by the program at intervals. To assist in the reevaluation, the state shall periodically conduct surveys of costs of pharmacy operation, including such components as overhead, professional services, and profits.

E. Drugs for Inpatients Receiving Nursing Facility Care

Drugs provided to inpatients in nursing facilities will be paid for in accordance with the reimbursement provisions contained herein except that reimbursement for drugs provided to patients in nursing facility brain injury units and nursing facility ventilator dependent units shall be as a part of the all inclusive rate for the unit and the payments for such drugs shall be in accordance with the MAC/EAC upper limits.

II. Physician Services

A. Definitions

(1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.

(2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.

(3) "Medical School Faculty Physician" is a physician who is employed by a state-supported school of medicine that is part of a university health care system that includes:

(a) a teaching hospital; and
(b) a state-owned pediatric teaching hospital; or
(c) an affiliation agreement with a pediatric teaching hospital.

B. Reimbursement

(1) Payment for covered physicians' services shall be based on the physicians' usual and customary actual billed charges up to the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS).

(2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

(2) RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors are as follows:

Types of Service	Kentucky Conversion Factor
Deliveries	Not applicable
Anesthesia (except delivery related)	$29.02
All Other Services	$29.67

C. Reimbursement Exceptions.

(1) Physicians will be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the Vaccines for Children Program to provide immunizations for Medicaid recipients under the age of twenty-one (21), with reimbursement for the cost of the drugs made by the Department for Medicaid Services to the Department for Public Health upon receipt of notice from the physicians that the drugs were used to provide immunizations to Medicaid recipients.

(2) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

Delivery only	$870.00
Vaginal delivery including postpartum care	$900.00
Cesarean delivery only	$870.00
Cesarean delivery including postpartum care	$900.00

(3) For delivery-related anesthesia services provided on or after July 1, 1995, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Vaginal delivery	$200.00
Epidural single	$315.00
Epidural continuous	$335.00
Cesarean section	$320.00

(4) Payment for individuals eligible for coverage under Medicare Part B is made, in accordance with Sections A and B and items (1) through (4) and (6) of this section within the individual's Medicare deductible and coinsurance liability.

(5) For services provided on or after July 1, 1990, family practice physicians practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the physicians' usual and customary actual billed charges up to 125 percent of the fixed upper limit per procedure established by the Department.

(6) For services provided on or after July 1, 1990, physician laboratory services shall be reimbursed based on the Medicare allowable payment rates. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.

(7) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the physician's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.

(8) Payments for the injection procedure for chemonucleolysis of invertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or at a fixed upper limit of $793.50 as established by the Department.

(9) Specified family planning procedures performed in the physician office setting shall be reimbursed at the lesser of the actual billed charge or the established RBRVS fee plus actual cost of the supply minus ten percent.

(10) Certain injectable anitbiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.

(11) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).

(12) For a practice-related service provided by a physician assistant, the participating physician shall be reimbursed at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the Department for Medicaid Services at seventy-five (75) percent of the physician's fixed upper limit per procedure.

(13) Any physician participating in the lock-in program will be paid a $10.00 per month lock-in fee for provision of patient management services for each recipient locked-in to that physician.

(14) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents who have entered into contractual agreements with medical schools for the assignment of payments in accordance with 42 CFR 447.10.

(15) The supplemental payments will be made on a quarterly basis in an amount which when combined with other payments under the plan, does not exceed the physicians' usual and customary charges.

D. Assurances. The state hereby assures that (1) payment for physician services are consistent with efficiency, economy, and quality of care (42 CFR 447.200); and (2) payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances (42 CFR 447.325).

III. Dental Services

A. Definitions.

For purposes of determination of payment usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.

"Dental School Faculty Dentist" is a dentist who is employed by a state-supported school of dentistry.

B. Reimbursement for Outpatient and Inpatient Services.

(1) The department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients at the dentist's actual billed charge not to exceed the fixed upper limit per procedure established by the department.

(2) With the exceptions specified in section (3), (4), and (5), the upper payment limit per procedure shall be established by increasing the limit in effect on 6/30/00 by 32.78%, rounded to the nearest dollar. This rate of increase is based upon an allocation of funds by the 2000 Kentucky General Assembly and a comparison to rates of other states based upon a survey of Dental Fees by the American Dental Association.

(3) If an upper payment limit is not established for a covered dental service in accordance with (2) above, the department shall establish an upper limit by the following:

a. The state will obtain no less than three (3) rates from other sources such as Medicare, Workmen's Compensation, private insurers or three (3) high volume Medicaid providers:
b. An average limit based upon these rates will be calculated; and
c. The calculated limit will be compared to rates for similar procedures to assure consistency with reimbursement for comparable services.

(4) The following reimbursement shall apply:

a. Orthodontic Consultation, $112.00, except that a fixed fee of $56.00 shall be paid if:

1. The provider is referring a recipient to a medical specialist;
2. The prior authorization for orthodontic services is not approved; or
3. A request for prior authorization for orthodontic services is not made.

b. Prior authorized early phase orthodontic services for moderately severe disabling malocclusions, $1,367 for orthodontists and $1,234 for general dentists..

c. Prior authorized orthodontic services for moderately severe disabling malocclusions, $1,825 for orthodontists and $1,649 for general dentists.

d. Prior authorized orthodontic services for severe disabling malocclusions, $2,754 for orthodontists and $2,455 for general dentists.

e. Prior authorized services for Temporomandinbular Joint (TMJ) therapy, an assessed rate per service not to exceed $424.

(5) This reimbursement methodology does not apply to oral surgeons' services that are included within the scope of their licenses. Those services are reimbursed in accordance with the reimbursement methodology for physician services.

(6) Medicaid reimbursement shall be made for medically necessary dental services provided in an inpatient or outpatient setting if:

a. The recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if provided in a dentist's office; and

b. In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in an inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

(7) In addition to payment for services as provided in this section, the department makes supplemental payments for services provided by dental school faculty either directly or as a supervisor of a dental resident. The supplemental payments are subject to funds available for this purpose and will be made on a quarterly basis in an amount when combined with other payments under the plan, do not exceed the dentist's usual and customary charges.

Preauthorized early phase orthodontic services for moderately severe or severe handicapping malocclusion, $1,200 for orthodontists and $1,080 for general dentists;

Preauthorized orthodontic services for moderately severe handicapping malocclusions, $1,600 for orthodontists and $1,440 for general dentists;

Preauthorized orthodontic services for severe handicapping malocclusions, $2,400 for orthodontists and $2,160 for general dentists;

(3) This reimbursement methodology does not apply to oral surgeons' services which are included within the scope of their oral surgery licenses. Those services are reimbursed as physicians' services rather than dentists' services.

(4) Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

IV. Vision Care Services

A. Definitions.

For purposes of determination of payment, "usual and customary actual billed charge" refers to the uniform amount the individual optometrist or ophthalmic dispenser charges in the majority of cases for a specific procedure or service.

B. Reimbursement for Covered Procedures and Materials for Optometrists.

(1) Reimbursement for covered services, within the optometrist's scope of licensure, except materials and laboratory services, shall be based on the optometrists' usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS). Fixed upper limits not determined in accordance with the RBRVS methodology (due to factors such as availability) shall be set by the department using the following methodology.

The fixed upper limit for the procedure shall be consistent with the general array of rates for the type of service. "General array of fixed rates" means that the rate upper limit set for the procedure will be at the same relative level, so far as possible, as the rates for procedures which are similar in nature. The listing of similar services is referred to as the "general array." The actual upper limit is derived by using not less than 3 other sources such as Medicare, Workman's Compensation, other federal programs, other state or local governments, and health insurance organizations or if a rate is not available from these sources then we solicit rates from at least 3 of the highest volume instate providers of the services. After obtaining at least 3 rates, the rates are added together then divided by the number of rates to obtain an average rate which is then compared to similar procedures paid in comparable circumstances by the Medicaid program to set the upper limit.

(2) With the exception of rates paid for dispensing services, fixed upper limits for vision services shall be calculated using the same RBRVS units as those used in the physicians services program, with the units multiplied by the "all other services" conversion factor to arrive at the fixed upper limit for each procedure.

(3) The upper payment limit for the following dispensing services shall be established by increasing the limit in effect on 6/30/00 to a fee no less than the Medicare allowable fee established for the service

(a) Fitting of spectacles;
(b) Special spectacles fitting; and
(c) Repair and adjustment of spectacles.

(4) Reimbursement for materials (eyeglasses or parts of eyeglasses) shall be made at the optical laboratory cost of the materials not to exceed upper limits for materials as set by the department. An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for post-payment review. The agency upper limits for materials are set based on the agency's best estimate of reasonable and economical rates at which the materials are widely and

consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometry Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

(5) Laboratory services shall be reimbursed at the actual billed amount not to exceed Medicare allowable reimbursement rates. If there is no established Medicare allowable reimbursement rate, the payment shall be sixty-five (65) percent of usual and customary actual billed charges.

C. Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers

Reimbursement for a covered service within the ophthalmic dispenser's scope of licensure shall be as described in Section B (above).

D. Effect of Third Party Liability

When payment for a covered service is due and payable from a third party source, such as private insurance, or some other third party with a legal obligation to pay, the amount payable by the department shall be reduced by the amount of the third party payment.

F. Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

V. Hearing Services

A. The State Agency shall reimburse a participating audiologist at usual and customary actual billed charges up to the fixed upper limit per procedure established by the State Agency at sixty-five (65) percent of the median billed charge using 1989 calendar year billed charges. If there is no median available for a procedure, or the State Agency determines that available data relating to the median for a procedure is unreliable, the State Agency shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. ("General array of fixed upper limits" means that the rate upper limit set for the procedure will be at the same relative level, so far as possible, as the upper limits for procedures which are similar in nature; the listing of similar services is what we referred to as a "general array.") Payment for a hearing aid furnished by the audiologist is reimbursed in the same manner as a hearing aid dealer.

Audiologists shall be entitled to the same dispensing fee or hearing aids as shown in Section B. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

B. Hearing Aid Dealers.

1. If the manufacturer of the hearing aid billed to the program has submitted a dealer price schedule which includes that hearing aid, the State Agency shall reimburse the participating hearing aid dealer at the lesser of:

a) That dealer price in the price schedule plus seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when the two hearing aids are dispensed on the same date;

b) Actual dealer cost plus a professional fee of seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date; or

c) The suggested retail price submitted by the manufacturer for that aid.

2. If the manufacturer of the hearing aid billed to the program has not submitted a dealer price schedule which includes that hearing aid, the State Agency shall reimburse that participating hearing aid dealer at the lessers of:

a) The lowest dealer price submitted for a comparable hearing aid plus a professional fee of seventy-five (75) dollars or at the actual dealer cost plus a professional fee of seventy-five (75) dollars or twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date;

b) The actual dealer cost plus a professional fee of seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date; or

c) The lowest suggested retail price submitted for a comparable aid. A comparable aid is defined as an aid falling within the general classification of fitting type, i.e., body, behind-the-ear, in-the-ear, eyeglasses.

c. Cords. The State Agency shall make payment for a replacement cord at the dealer's cost, plus professional fee set at the fixed upper limit

D. Hearing Aid Repairs. The State Agency shall reimburse a hearing aid dealer for a hearing aid repair on the basis of the manufacturer's charge for repair or replacement of parts, plus the dealer's cost for postage and insurance relative to the repair, plus a professional fee set at the fixed upper limit.

VI. Screening Services

A. The state agency shall reimburse individual providers for screening services in accordance with their usual payment procedures outlined in this state plan.

B. The state agency shall reimburse screening clinics or agencies on the basis of a pre-established fee which shall be related to the cost of service as follows:

(1) For a complete screening which includes all items or procedures appropriate to age and health history of the recipient, except the fifth year (kindergarten examination)and twelfth year (sixth grade examination), the fee shall be seventy (70) dollars per recipient screened;

(2) For a complete screening for the fifth and twelfth years, the fee shall be ninety (90) dollars per recipient screened;

(3) For a partial screening, which shall include at least a health history and unclothed physical examination, the fee shall be thirty (30) dollars per recipient screened;

(4) For completion of a partial screening with some items or procedures appropriate to age and health history of the recipient provided as a follow-up to a partial screening, the fee shall be forty (40) dollars per recipient screened.

(5) For an interperiodic screen, which shall be medically necessary to determine the existence of a suspected physical or mental illness and in addition to the regular periodicity scheduled screenings, the fee shall be thirty (30) dollars per recipient screened.

(6) In no instance may the fee paid in accordance with items (1) through (5) exceed the usual and customary fee of the provider for the service.

VI-A. Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

(1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services) the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:

(a) 1905(a)(1), inpatient hospital services;
(b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
(c) 1905(a)(3), other laboratory and X-ray services;
(d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
(e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
(f) 1905(a)(6), medical care by other licensed practitioners;
(g) 1905(a)(7), home health care services;
(h) 1905(a)(9), clinic services;
(i) 1905(a)(10), dental services;
(j) 1905(a)(11), physical therapy and related services;
(k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
(l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
(m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
(n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
(o) 1905(a)(17), nurse-midwife services;
(p) 1905(a)(18), hospice care;
(q) 1905(a)(19), case management services; and
(r) 1905(a)(~~21~~ 22), other medical and remedial care specified by the Secretary. P&I HCFA 5-15-92

(2) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21 the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100% of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

(a) Any service described in 1, above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
(b) 1905(a)(8), private duty nursing services;
(c) 1905(a)(20), respiratory care services;
(d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and
(e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitoriums, and personal care services in a recipient's home.

VII. Transportation Services

A. Ambulance Services.

(1) The department shall reimburse licensed participating ambulance services at the lesser of their usual and customary charges or the maximum rate established by the department.

(2) The maximum rate shall be the amount arrived at by combining the base rate, mileage allowance, oxygen rate, and cost of other supplies, as applicable:

(a) The base rate for Advanced Life Support (ALS) emergency transportation to the emergency room of a hospital shall be set at eighty-five (85) dollars per one (1) way trip; the mileage allowance for trips shall be three (3) dollars and fifty (50) cents per mile for mileage from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional allowance for mileage.

(b) The rate for air ambulance transportation shall be an all-inclusive rate. Reimbursement shall be the provider's usual and customary charge not to exceed the upper limit of $3,500. All claims for air ambulance transportation services shall be submitted to the Department for Medicaid Services and shall be reviewed for determination that air transport was medically necessary and appropriate.

(c) The base rate for Basic Life Support (BLS) emergency transportation to the emergency room of a hospital shall be set at sixty-five (65) dollars per one (1) way trip; the mileage allowance for trips shall be two (2) dollars and fifty (50) cents per mile for mileage from mile one (1); a flat rate of twenty (20) dollars shall be set for each additional recipient with no additional allowance for mileage.

(d) The base rate for any ALS or BLS providing emergency ambulance transportation to an appropriate medical facility or provider which is not the emergency room of a hospital shall be set at fifty-five (55) dollars per one (1) way trip; the mileage allowance for trips shall be two (2) dollars per mile for mileage from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage. Payment shall be contingent upon review of required documentation. Claims shall be reviewed by the Department for Medicaid Services. Required documentation shall be a statement of a medical emergency by the attending medical provider.

(e) The base rate for nonemergency health transportation (NEHT) services when transporting a recipient who is on a stretcher to a medical provider, other than a pharmacy, shall be set at forty (40) dollars per one (1) way trip; the mileage allowance for trips shall be one (1) dollar and fifty (50) cents per mile. The reimbursement for NEHT services when transporting a recipient who is in a wheelchair shall be as a specialty carrier.

(f) The base rate for nonemergency transportation for all licensed ambulance services when no medical care or treatment of a recipient is required or indicated during transport shall be the rate specified in item (e) of this section.

(g) An oxygen rate, will be set at ten (10) dollars per one (1) way trip; for all licensed ambulance services, excluding air ambulances.

(h) The cost of other itemized supplies for ALS or BLS emergency transportation services shall be the actual cost as reflected on the transportation provider's invoice which shall be maintained in the provider's files and shall be produced upon request by the department.

B. Commercial Transportation Carriers

The department shall reimburse participating commercial transportation carriers at usual commercial rates with limitations as follows:

(1) For taxi services provided in regulated areas the provider shall be reimbursed the normal passenger rate charged to the general public for a one (1) way trip regardless of the number of Medicaid eligible recipients transported when the trip is within the medical service area. The taxi shall be paid the single passenger rate regardless of the number of additional passengers.

(2) For taxi services in those areas of the state where taxi rates are not regulated by the appropriate local rate setting authority, and for taxi services in regulated areas when they go outside the medical service area, the provider shall be reimbursed the normal passenger rate charged the general public for a single passenger (without payment for additional passengers, if any) up to the upper limit; reimbursement for transport of a parent or attendant shall be considered included within the upper limit allowed for the trip. The upper limit for a taxi transporting a recipient shall be:

(a) The usual and customary charge up to a maximum of six (6) dollars for trips of five (5) miles or less, one (1) way, loaded miles.

(b) The usual and customary charge up to a maximum of twelve (12) dollars for trips of six (6) to ten (10) miles, one (1) way, loaded miles.

(c) The usual and customary charge up to a maximum of twenty (20) dollars for trips of eleven (11) to twenty-five (25) miles, one (1) way, loaded miles.

(d) The usual and customary charge up to a maximum of thirty (30) dollars for trips of twenty-six (26) miles to fifty (50) miles, one (1) way, loaded miles.

(e) For trips of fifty-one (51) miles or above shall be the lesser of the usual and customary charge or an amount derived by multiplying one (1) dollar by the actual number of miles, not to exceed a maximum of seventy-five (75) dollars per trip, one (1) way, loaded miles.

C. Private Automobile Carriers.

(1) The department shall reimburse private automobile carriers at the basic rate of twenty-two (22) cents per mile plus a flat fee of four (4) dollars per recipient if waiting time is required. For round trips of less than five (5) miles the rate shall be computed on the basis of a maximum allowable fee of six (6) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. Private automobile carriers shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing reimbursable medical transportation services.

(2) For round trips of five (5) to twenty-five (25) miles the rate for private automobile carriers shall be computed on the basis of maximum allowable fee of ten (10) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. The maximum allowable fee rates shall not be utilized in situations where mileage is paid.

(3) Even though the maximum allowable fee rate when computed on the basis of twenty-two (22) cents per mile plus four (4) dollars for waiting time would not equal the six (6) dollars or ten (10) dollars allowable amounts, the higher amount is paid to encourage private automobile carriers to provide necessary medical transportation. Additionally, nothing in this section requires the department to pay the amounts specified if the private automobile carrier expresses a preference for reimbursement in a lesser amount; then the lesser amount shall be paid. Toll charges shall be reimbursable when presented with a receipt.

(4) Waiting time shall be a reimbursable component of the private automobile carrier transportation fee only if waiting time occurs. If waiting time occurs due to admittance of the recipient into the medical institution, the private automobile carrier may be reimbursed for the return trip to the point of recipient pick-up as though the recipient were in the vehicle; that is, the total reimbursable amount shall be computed on the basis of the maximum allowable fee or mileage rate plus waiting time. Waiting time shall not be paid for the attendant or caretaker relative (e.g., mother, father) who is accompanying the recipient and not personally being transported for Medicaid covered service.

(5) If a private automobile carrier is transporting more than one (1) recipient, only one (1) mileage payment shall be allowed. Mileage shall be computed on the basis of the distance between the most remote recipient and the most remote medical service utilized; and will include any necessary additional mileage to pickup and discharge the additional recipients.

D. Non-Commercial Group Carriers.

(1) The department shall reimburse participating non-commercial group carriers based on actual reasonable, allowable cost to the provider based on cost data submitted to the department by the provider.

(2) The minimum rate shall be twenty (20) cents per recipient per mile transported and the rate upper limit shall be fifty (50) cents per recipient per mile transported.

(3) Payment for a parent or other attendant shall be at the usual recipient rate.

E. Specialty Carriers.

(1) Participating specialty carriers shall be reimbursed at the lesser of the following rates:

(a) The actual charge for the service; or

(b) The usual and customary charge for that service by the carrier, as shown in the schedule of usual and customary charges submitted by the carrier to the department; or

(c) The program maximum established for the service.

(2) Program maximums shall be:

(a) For nonambulatory recipients who require the use of a wheelchair, the upper limit shall be twenty-five (25) dollars for the first recipient plus four (4) dollars for each additional nonambulatory recipient transported on the same trip, for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollar and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and certified; mileage charges shall not be allowed for additional recipients.

(b) For ambulatory recipients who are disoriented, the upper limit shall be twelve (12) dollars and fifty (50) cents for the first recipient plus four (4) dollars for each additional disoriented recipient transported on the same trip for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollars and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and verified; mileage charges shall not be allowed for additional recipients.

(c) For both paragraphs (a) and (b) of this section, empty vehicle miles shall not be included when computing allowable reimbursement for mileage.

(3) Reimbursement shall be made at specialty carrier rates for the following types of recipients only:

(a) Nonambulatory recipients who need to be transported by wheelchair, but shall not include recipients who need to be transported as stretcher patients; and

(b) Ambulatory recipients who are disoriented.

(4) The specialty carrier shall obtain a statement from the recipient's physician (or, if the recipient is in a nursing facility, from the director of nursing, charge nurse, or medical director in lieu of physician) to verify that transportation by the specialty carrier is medically necessary due to the recipient's nonambulatory or disoriented condition. Claims for payment which are submitted without the required statement of verification shall not be paid.

F. Specially authorized transportation services authorized in unforeseen circumstances may be paid for at a rate adequate to secure the necessary service; the amount allowed shall not exceed the usual and customary charge of the provider. The Department for Medicaid Services shall review and approve or disapprove requests for specially authorized transportation services based on medical necessity.

G. Use of flat rates.

Transportation payment shall not exceed the lesser of six (6) dollars per trip, one (1) way (or twelve (12) dollars for a round trip), or the usual fee for the participating transportation provider computed in the usual manner if:

(1) The recipient chooses to use a medical provider outside the medical service area; and

(2) The medical service is available in the recipient's medical service area; and

(3) The recipient has not been appropriately referred by the medical provider within his medical service area.

H. Meals and Lodging.

The flat rate for meals and lodgings for recipients and attendants when preauthorized (or post-authorized if appropriate) by the department shall be as follows:

(1) Standard Area:

(a) Meals: breakfast-$4 per day; lunch-$5 per day; dinner-$11 per day; and

(b) Lodgings: $40 per day

(2) High Rate Area:

(a) Meals: breakfast-$5 per day; lunch-$6 per day; dinner-$15 per day; and

(b) Lodgings: $55 per day.

I. Limitations.

(1) Any reimbursement for medical transportation shall be contingent upon the recipient receiving the appropriate preauthorization or postauthorization for medical transportation as required by the Department for Medicaid Services.

(2) (a) Authorization shall not be granted for recipients transported for purposes other than to take the recipient to or from covered Medicaid services being provided to that recipient, except in the instance of one (1) parent accompanying a child to or from covered medical services being provided to the child or if one (1) attendant is authorized for a recipient traveling to or from covered medical services based on medical condition of the recipient.

(b) Reimbursement shall be limited to transportation services and shall not include the services, salary or time of the attendant or parent.

(3) An individual who owns a taxi company and who uses the taxi as his personal vehicle shall be reimbursed at the private auto rate when transporting household family members.

(4) Mileage for reimbursement purposes shall be computed by the most direct accessible route from point of pickup to point of delivery.

VIII. Outpatient Hospital Services

A. Effective for services provided on and after April 1, 2001 payments for in-state outpatient hospital services will be made on an interim basis. The interim payments will be calculated by multiplying the hospitals Medicaid billed outpatient service charges by the hospital's facility-specific cost-to-charge ratio. This ratio is determined by dividing its Medicaid allowable cost of covered outpatient services from its most recently settled cost report by the hospital's Medicaid billed charges for covered outpatient services for the same report period. There will be a lower of cost of charges year-end settlement for covered outpatient services.

B. Effective for services provided on and after April 1, 2001, outpatient services provided by an out-of-state hospital will be reimbursed at sixty-five (65) percent of Medicaid billed charges with no settlement to the lower of cost or charges.

Effective for services provided on and after July 2, 2001, out-of-state hospitals will be reimbursed in accordance with the following:

1. Out-of-state hospitals providing in excess of $100,000 in paid claims for the previous year (July 1 to June 30) will be required to submit a copy of their most recent Medicare cost report. On an interim basis for the period of July 1, 2001 to September 1, 2001, reimbursement will be determined based on the Kentucky statewide average cost-to-charge ratio, (i.e., cost-to-charge ratio x billed charges) for in-state hospitals. Once the department receives a cost report, reimbursement will be as described above in VIII. A. Failure to provide the required cost report will result in a reduction of future payments to the lesser of the payment based on the most current cost report data or payment based on the Kentucky statewide average cost-to-charge ratio.

2. Out-of-state hospitals providing less than $100,000 in paid claims for the previous year (July 1 to June 30) will not be required to submit a copy of their most recent Medicare cost report. Reimbursement will be made by multiplying the Kentucky statewide average cost-to-charge ratio x billed charges. Annually, the department will determine the average statewide cost-to-charge ratio for all in-state hospitals.

C. Charges or costs shall not be transferred between the inpatient and outpatient service units.

D. Outpatient hospital laboratory services will be paid based on the Medicare allowable payment rates.

E. Outpatient hospital laboratory services with no established Medicare payment rate will be reimbursed at sixty-five (65) percent of Medicaid billed charges with no settlement to the lower of cost or charges.

F. Supplemental Payments to Non-state Government-owned or Operated Hospitals.

1. The Department provides quarterly supplemental payments to non-state government-owned or operated hospitals for outpatient services provided to Medicaid recipients. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.

2. To qualify for a supplemental payment, a hospital must be a non-state government-owned or operated hospital that has entered into an Intergovernmental Transfer Agreement with the Commonwealth. The payment amount for a qualifying hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all qualifying hospitals for the same fiscal year.

G. Emergency Room Services

1. Effective for services provided on and after September 1, 2002, the Department will reimburse for emergency room services at a flat rate per visit based upon the level of service provided. In addition, diagnostic and radiological procedures will be paid at specific rates.

2. There shall be rates for three (3) levels of service and an assessment fee:
   - Level I shall be those services billed using CPT codes 99281 and 99282, reimbursed at $82.00.
   - Level II shall be those services billed using CPT codes 99283 and 99284, reimbursed at $164.00.
   - Level III shall be those services billed using CPT codes 99285, reimbursed at $264.00
   - An assessment, or triage, shall be payable at $20.00

   Included in the flat rate are pharmacy (except for thrombolytic agents), medical supplies, radiology (except as described in 4 below), laboratory, physical and respiratory therapy, electrocardiogram, and electroencephalogram.

3. The flat rates per visit were calculated in accordance with the following:

   The Level II rate was calculated by multiplying the average costs for Level II services in state fiscal years 2000 and 2001 (adjusted by the moving average of Data Resources, Inc. for the Hospital Market Basket) by .75.

   The Level I rate is established at 50% of the Level II rate.
   The Level III rate is established at $100 higher than the Level II rate.

4. Separate rates were established for the following:

   The rates for treatment procedures including cardiac catheterization and lithotripsy are calculated at 150% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

   The rates for diagnostic procedures including CT scans, ultra sounds, and magnetic reasoning imaging are calculated at 100% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

   The rate for observation are calculated at 100% of the average adjusted costs for state fiscal years 2000 and 2001.

5. Thrombolyptic agents shall be reimbursed at acquisition costs.

X. Home Health Agency Services

(1) The following home health services are reimbursed at the lower of an upper payment limit established by the state Medicaid agency or the actual billed charge:

Skilled Nursing
Home Health Aide
Medical Social Service
Physical, Occupational and Speech Therapy

(2) The payment for enteral nutritional products and disposable medical supplies shall be an interim payment rate established by the state Medicaid agency by calculating the providers total cost to charge ratio for the items as reported on the home health agencies most recent available cost report as of May 31 immediately preceding the rate year. Interim payments shall not exceed the providers charges billed for these items. Interim payments will be settled back to actual cost at the end of the home health agency's fiscal year. Home health agencies that are operated by public providers shall not be settled to the lower of cost or charges. These home health agencies shall be reimbursed their total allowable cost.

(3) Payment to a new home health agency shall be the lesser of billed charges or the statewide upper payment limit established by the state Medicaid agency for all home health services except for enteral nutritional products and disposable medical supplies. Payment to a new home health agency for enteral nutritional products and disposable medical supplies will be seventy (70) percent of the new home health agency's usual and customary actual billed charges. A new home health agency will be held to the seventy (70) percent threshold until a cost report is accepted by the state Medicaid agency no later than May 31 preceding the rate year. Interim payments will be settled back to actual cost at the end of the agency's fiscal year.

(4) Payment to an out of state home health agency shall be the lessor of billed charges or the statewide upper payment limit established by the state Medicaid agency for all home health services except for enteral nutritional products and disposable medical supplies. Payment to an out of state home health agency for enteral nutritional products and disposable medical supplies will be eighty (80) percent of the out of state agency's usual and customary actual billed charges.

XI. Laboratory Services

Eff. 7-1-88 The State Agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics for covered laboratory services rendered on the basis of the allowable payment rates set by Medicare.

XII. (Deleted)

XIII. Family Planning Clinics

Eff. 7-1-87 The State Agency will reimburse participating family planning agencies for covered services in accordance with 42 CFR Section 447.321; payments shall not exceed applicable Title XVIII upper limits. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall not exceed the following amounts:

	Physicians	ARNP
Initial Clinic Visit	$50.00	$37.75
Annual Clinic Visit	$60.00	$45.00
Follow-up Visit with Pelvic Examination	$25.00	$18.75
Follow-up Visit without Pelvic Examination	$20.00	$15.00
Counseling Visit	$13.00	$13.00
Counseling Visit w/3 months contraceptive supply	$17.00	$17.00
Counseling Visit w/6 months contraceptive supply	$20.00	$20.00
Supply Only Visit - Actual acquisition cost of contraceptive supplies dispensed		

XIV. Durable Medical Equipment, Supplies, Prosthetics and Orthotics

1. General DME Items

For DME items that have an HCPC code (except for customized items) reimbursement shall be based on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.

2. Manual Pricing of DME Items

a. Customized items with a miscellaneous HCPC code of K0108 will require prior-authorization and will be reimbursed at invoice plus twenty-two (22) percent, not to exceed the supplier's usual and customary charge.

b. Customized components that do not have an HCPC code will require prior-authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.

c. DME items that do not have HCPC codes will require prior authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.

d. Specialized wheelchair bases will require prior-authorization and will be reimbursed at manufacturers suggested retail price minus fifteen (15) percent, not to exceed the supplier's usual and customary charge.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers and primary care centers shall be reimbursed in accordance with the limitations in 42 CFR 447.321.

A. Community mental health centers.

1. Participating in-state mental health centers shall be reimbursed as follows:

   a. The department shall establish final prospective rates for each direct service cost center using audited annual cost reports for the prior year. If an audited costs report is not available, the most recent unaudited cost report shall be used with the rate adjusted as necessary at the time of audit or desk review.

   b. Cost used in setting the rates shall be trended to the beginning of the rate year and indexed for inflation using the Home Health Agency Market Basket National Forecast.

   c. Direct service costs shall be arrayed and an upper limit set at 130 percent of the median cost per unit.

   d. The base rate per unit shall be the allowable cost or the upper limit, whichever is less.

   e. In addition to the base rate per unit, each center shall receive a cost savings incentive payment equal to fifteen (15) percent of the difference between the facility's allowable cost and the upper limit.

   f. A funding adjustment equal to $1.3 million shall be distributed based on the number of outpatient units of service provided. This adjustment is to improve services and to encourage the provision of additional services.

   g. The reimbursable departmental cost centers are on-site psychiatrist, on-site individual, off-site psychiatrist, off-site individual, group, personal care, therapeutic rehabilitation, inpatient hospital psychiatrist, inpatient hospital other, universal prevention, selective prevention, indicated prevention, outpatient, assessment, day rehabilitation, case management, and community support.

2. Participating out-of-state mental health center providers shall be reimbursed the lower of charges, or the facility's rate as set by the state Medicaid Program in the other state, or the upper limit for that type of service in effect for Kentucky providers.

2. For state fiscal year July 1, 2002 - June 30, 2003, the payment rates for other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers will be the rates that were in effect on June 30, 2002.

Payment methodology for rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and that are provided through an agreement with the State Health or Title V agency.

A. Rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rates for rehabilitative services are negotiated rates between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of each service.

The payment rate for rehabilitative services that are authorized after June 30, 2002, are uniform rates, determined by 98% of the weighted median of claims for each service for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

B. Rehabilitative services for children under the supervision of the state and that are provided through an agreement with the State Health or Title V agency.

Payments for rehabilitative services covered in Attachment 3.1-A, page 7.6.1 and Attachment 3.1B, page 31.5 for the target populations are per service. They are based upon one or more documented rehabilitative services provided to each client. The rates for the rehabilitative services are based upon the actual direct and indirect costs to the providers. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing rehabilitative services based on financial information submitted by the provider.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: identification, by recipient and worker, of each individual service provided, a showing of all direct costs for rehabilitative services; and a showing of all indirect costs for rehabilitative services appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principle if necessary.

Rehabilitative service providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

B. Effective for services provided on and after July 2, 2001, primary care centers will be reimbursed in accordance with the prospective payment system described in Attachment 4.19-B, page 20.16 for FQHCs and RHCs.

For drugs for specified immunizations provided free from the Health Department to primary care centers for immunizations for Medicaid recipients, the cost of the drugs are paid to the Health Department. The specified immunizations are: diphteria and tetanus toxiods and pertuisis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any type(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

Effective January 1, 1989, the cost for these immunizations will not be allowed as a part of the primary care center cost base so long as these drugs are available free from the Health Department.

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XVII. FQHC/RHC Services

Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) shall be made in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA).

For the period of January 1, 2001 through June 30, 2001, the state will implement an alternative reimbursement methodology that is agreed to by the state and the individual center/clinic and results in a payment rate to the center/clinic that is at least equal to the Medicaid PPS rate. The alternative methodology shall be in accordance with the state plan in effect on December 31, 2000.

All FQHCs and RHCs are reimbursed on a prospective payment system beginning with State Fiscal Year 2002 with respect to services furnished on or after July 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the clinic/center's reasonable cost for the clinic/center's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic/center's fiscal year 2001 and increased by an appropriate medical index. These costs are divided by the number of visits/encounters for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for state fiscal year 2002. For each state fiscal year thereafter, each clinic/center will be paid the amount (on a per visit basis) equal to the amount paid in the previous state fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that state fiscal year. The clinic/center must supply a budgeted cost report of the change in service to justify scope of service adjustments.

For newly qualified FQHCs/RHCs after State Fiscal Year 2001, initial payments are established by cost reporting methods. A newly qualified clinic/center shall submit a budgeted cost report from which an interim rate shall be established. After completion of a clinic/center fiscal year, a final PPS rate will be established. After the initial year, payment is set using the MEI methods used by other clinics/centers, with adjustments for increases or decreases in the scope of service furnished by the clinic/center during that fiscal year.

In the case of a FQHC or RHC that contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the center or clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the center or clinic is entitled under the PPS.

Until a prospective payment methodology is established, the state will reimburse FQHCs/RHCs based on the rate in effect on June 30, 2001. This rate is based on the State Plan in effect on June 30, 2001. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

State Kentucky

Eff. 7-1-88

XVIII. Outpatient Surgical Clinics

Reimbursement will be made to freestanding outpatient surgical clinics on the basis of sixty-five (65) percent of their usual and customary charge for the procedure performed. Payment rates shall not exceed the provider's usual and customary charge to the general public. Hospital based outpatient surgical clinics shall be reimbursed in the same manner as hospital outpatient services.

XIX Nurse-Midwife Services

Participating nurse-midwife providers shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of the nurse-midwife.

For services provided on or after July 1, 1990, payments to nurse-midwives shall be at usual and customary actual billed charges on a procedure-by-procedure basis, with reimbursement for each procedure to be the lesser of the actual billed charge or at seventy-five (75) percent of the fixed upper limit per procedure for physicians.

XX Nurse anesthetist services

Reimbursement will be made at the rate of seventy-five (75) percent of the anesthesiologist's allowable charge for the same procedure under the same conditions, or at actual billed charges if less.

Exception:

For inpatient delivery-related anesthesia services provided on or after December 1, 1988, a nurse anesthetist will be reimbursed the lesser of the actual billed charge or the standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Normal Delivery, $150.00;
Low Cervical C-Section, $202.50;
Classic C-Section, $240.00;
Epidural Single, $236.25;
Epidural Continuous, $251.25;
C-Section with Hysterectomy, subtotal, $240.00;
C-Section with Hysterectomy, total, $240.00;
Extraperitoneal C-Section, $240.00

XXI. Podiatry Services

The cabinet shall reimburse licensed, participating podiatrists for covered podiatry services rendered to eligible Medical Assistance recipients at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the cabinet at 65 percent of the median billed charge for outpatient services and 50 percent of the median billed charge for inpatient services using 1989 calendar year billed charges. If there is no median available for a procedure, or the cabinet determines that available data relating to the median for a procedure is unreliable, the cabinet shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

XXII Hospice Services

Reimbursement for licensed, participating hospices shall be at the rates provided for in Section 9505(c) of Public Law 99-272 (COBRA). In addition, for hospice patients in nursing facility beds participating in the Medicaid Program, the hospice shall be paid an amount for room and board furnished by the facility which is equal to ninety-five (95) percent of the Medicaid rate for the facility.

XXIII. Case Management Services

A. Targeted case management services for severely emotionally disturbed children and adults with chronic mental illness.

Providers are paid a uniform interim rate. The uniform interim rate approximates an average of provider actual costs from the previous year. Prior to July 1, 2002, the uniform interim rate was settled to individual provider actual cost at the end of the state's fiscal year. Providers are required to submit an independently audited cost report as acceptable documentation of actual cost.

The billable unit of service is one month.

For state fiscal year July 1, 2002 - June 30, 2003, the uniform interim rate will be the final rate, and will not be settled to provider actual cost.

B. Targeted case management services for children with developmental disabilities provided through an agreement with the Title V Agency.

Payments for case management services are on a per encounter or per item basis. Payments shall be based on documented costs for the direct provision of services. Documented costs do not include payment for administrative and indirect overhead costs of the Title V agency or its contractor state agency, the Department for Mental Health and Mental Retardation Services. The Title V Agency, (or its contractor state agency, the Department for Mental Health and Mental Retardation Services) must maintain, in auditable form, all records of expenditures for services for which claims of reimbursement are made to the Medicaid agency. Payments to state agencies shall not exceed actual documented costs. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year.

XXV. Advanced Registered Nurse Practitioner Services

(1) Reimbursement

a. Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of a licensed ARNP.

b. Except as specified in subsection c of this section or Section 2 below, reimbursement for a procedure provided by an ARNP shall be at the lesser of the following:
   1. The ARNP's actual billed charge for the service; or
   2. Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.

c. An ARNP employed by a primary care center, federally qualified health center, hospital, or comprehensive care center shall not be reimbursed directly for services provide in that setting while operating as an employee.

(2) Reimbursement Limitations.

a. The fee for administration of a vaccine to a Medicaid recipient under the age of twenty-one (21) by an ARNP shall be three (3) dollars and thirty (30) cents up to three (3) administrations per ARNP, per recipient, per date of service.

b. The cost of a vaccine available free through the Vaccines for Children Program shall not be reimbursed.

c. Injectable antibiotics, antineoplastic chemotherapy, and contraceptives shall be reimbursed at the lesser of:
   1. The actual billed charge; or
   2. The average wholesale price of the medication supply minus ten (10) percent.

d. Reimbursement for an anesthesia service provided during a procedure shall be inclusive of the following elements:
   1. Preoperative and post-operative visits;
   2. Administration of the anesthetic;
   3. Administration of intravenous fluids and blood or blood products incidental to the anesthesia or surgery;
   4. Post-operative pain management; and
   5. Monitoring services.

e. Reimbursement of a psychiatric service provided by an ARNP shall be limited to four (4) psychiatric services per ARNP, per recipient, per twelve (12) months.

f. Reimbursement for a laboratory service provided in an office setting shall be inclusive of:
   1. The fee for collecting and analyzing the specimen; and
   2. Should the test require an arterial puncture or venipuncture, the fee for the puncture.

g. Reimbursement shall be limited to one (1) of the following evaluation and management services performed by an ARNP per recipient, per date of service:
   1. A consultation service;
   2. A critical care service;
   3. An emergency department evaluation and management service;
   4. A home evaluation and management service;
   5. A hospital inpatient evaluation and management service;
   6. A nursing facility service;
   7. An office or other outpatient evaluation and management service;
   8. A preventive medicine service; or
   9. A psychiatric or other psychotherapy service.

XXVI: Federally Qualified Health Center Services

Enrolled Federally Qualified Health Center providers shall be paid full reasonable cost determined in the same manner as for primary care centers except that cost shall not include an incentive payment.

XXIX Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

(1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services), the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:

(a) 1905(a)(1), inpatient hospital services;
(b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
(c) 1905(a)(3), other laboratory and X-ray services;
(d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
(e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
(f) 1905(a)(6), medical care by other licensed practitioners;
(g) 1905(a)(7), home health care services;
(h) 1905(a)(9), clinic services;
(i) 1905(a)(10), dental services;
(j) 1905(a)(11), physical therapy and related services;
(k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
(l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
(m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
(n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
(o) 1905(a)(17), nurse-midwife services;
(p) 1905(a)(18), hospice care;
(q) 1905(a)(19), case management services; and
(r) 1905(a)(22), other medical and remedial care specified by the Secretary.

(2) For medically-necessary evaluative, diagnostic, preventive, and treatment services listed in Section 1905(a) of the Social Security Act included in an Individual Education Program under the provisions of the Individuals with Disabilities Education Act, the state shall pay in accordance with items (1) or (3), as applicable, except that for public providers the payment shall be a fee-for-service system designed to approximate cost in the aggregate without settlement to exact cost. The following describes the methodology utilized in arriving at the rates.

(a) The aggregate will be calculated for all participating public providers in the state. Initial interim rates will be established using data provided by the Department of Education from most of the public providers in the state and data gathered in surveys. During the first year, participating providers will be required to provide data which will be used to calculate final rates; claims paid using the interim rates will be adjusted after final rates have been established. This process will be repeated each state fiscal year as new providers are added and as previously participating providers experience changes with regard to their costs. Through this process, cost in the aggregate will only reflect the cost of participating providers on a statewide basis.

(b) Payments to public providers are based on a statewide fee for each procedure code. A fee for a particular procedure code is based on the lower of the mean or median statewide cost of providing the service. The statewide mean and median cost to participating providers for a service is based on a 100 percent sample of the contracted service cost and/or cost associated with publicly employed professionals. Cost for publicly employed professionals consists of salary, fringe benefits and indirect overhead. Annual professional salaries are converted to hourly wages using 185 work days per year and six (6) work hours per day. For salaried employees the public provider fringe benefit rates for classified employees and for certified employees will be used. Indirect overhead cost computed at the rate of seven (7) percent of hourly wage salaries is added to the hourly wage rate and the fringe benefits to establish their hourly cost.

(c) The mean and median hourly rate is calculated, for each class of qualified professionals, from an array of hourly cost data falling within one standard deviation of the mean. The resultant hourly rates are converted to fifteen (15) minute service units.

(d) The following two (2) exceptions to usual cost reimbursement will be applicable: first, for emergency medical transportation, reimbursement will be based on the average cost per mile of pupil transportation calculated by the Kentucky Department of Education; and, second, for assistive technology, reimbursement will be based on the actual invoiced cost for the IEP authorized equipment. Transportation will be paid based on units of one (1) mile.

(3) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21, the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100 percent of usual and customary

charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

(a) Any service described in one (1), above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
(b) 1905(a)(8), private duty nursing services;
(c) 1905(a)(20), respiratory care services;
(d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and
(e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitariums, and personal care services in a recipient's home.

State Kentucky

XXX. Radiological (X-ray) Services

Payments for radiological services covered pursuant to the mandate contained in 42 CFR 440.30 shall be at usual and customary charges up to sixty (60) percent of the allowable physician fee for the same procedures where the physician is performing both the professional and technical portions of the service.

XXXI. Payment methodology for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and for adults in need of protective services.

A. Targeted case management services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rate for targeted case management is a negotiated rate between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of the service.

The payment rate for a targeted case management service that is authorized after June 30, 2002, is a uniform rate, determined by 98% of the weighted median of claims for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

The billable unit of service is one month

B. Targeted case management services for children under the supervision of the state and for adults in need of protective services.

Payments for targeted case management services for the target populations are monthly. They are based upon one or more documented targeted case management services provided to each client during that month. The monthly rate for the targeted case management services is based on the total average cost per client served by the provider. The monthly rate is established on a prospective basis based upon actual case management costs for the previous year. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing case management services based on financial information submitted by the provider.

Case management providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: directly coded worker time; identification, by recipient and worker, of each individual service provided, a showing of all direct costs for case management activities; and a showing of all indirect costs for case management activities appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principles if necessary.

XXXII. Specialized Children's Services Clinics

Clinic services provided by Specialized Children's Services Clinics will be reimbursed initially at a statewide uniform all-inclusive rate per visit (encounter rate) of $538. This rate is estimated to approximate the average statewide costs of all clinics providing the service. This rate includes the costs of professional services (physician and mental health professional), related costs of providing a sexual abuse exam, and facility costs (overhead). This rate is based on the projected cost of providing the service as submitted to the department by the providers and a consideration of rates paid to providers for similar services.

Providers will submit cost reports annually. Upon receipt of completed cost reports from all clinics, the department will establish a rate within 90 days using updated cost data.

Payments made under this provision shall not exceed the upper limit of payment as specified in 42 CFR 447.325.

XXIII. Targeted Case Management and Diagnostic, Preventive and Rehabilitative Early Intervention Services for children eligible for the Early Intervention program provided through a Title V agreement.

This payment system is for all providers, including those providing services under the Title V agreement described in Supplement 1 to Attachment 4.16-A, Item #10.

All costs shall be determined based on the methodology outlined in OMB Circular A-87. Payments for case management, diagnostic, rehabilitative, and preventive early intervention services shall be made in accordance with a fee schedule established by the Title V agency. Interim payments shall be based on the direct cost of providing the service. Payments for overhead and administrative costs associated with providing the service shall be determined with a settlement to cost at the end of the fiscal year. Providers will submit cost reports no later than 180 days after the end of the state fiscal year.

XXXIV. Rehabilitation Services for Pregnant Women

Substance abuse services covered for pregnant women including postpartum women for a sixty (60) day period after the pregnancy ends and any remaining days in the month in which the 60th day falls, provided by any mental health centers, their subcontractors and any other qualified providers, licensed in accordance with applicable state laws and regulations. Payment for these services will be based on cost in accordance with attachment 4.19-B, pages 20.15-20.15.5.

Reimbursement for services shall be based on the following units of service:

Universal prevention service shall be a one-quarter (1/4) hour unit;
Selective prevention service shall be a one-quarter (1/4) hour unit;
Indicated prevention service shall be a one-quarter (1/4) hour unit;
Outpatient service shall be a one-quarter (1/4) hour unit for the following modalities:

- Individual therapy;
- Group therapy;
- Family therapy;
- Psychiatric evaluation;
- Psychological testing;
- Medication management; and
- Collateral care;

An assessment service shall be a one-quarter (1/4) hour outpatient unit;
Day rehabilitation services shall be a one (1) hour unit;
Case management services shall be a one-quarter (1/4) hour unit; and
Community support shall be a one-quarter (1/4) hour unit;

Targeted case management services for at risk parents during the prenatal period and until the child's third birthday

This payment system is for all providers, including those providing services under the Title V agreement described in Attachment 4.16-A, Item #10.

Payments shall be based on cost. Interim rates based on projected cost shall be used with a settlement to cost at the end of the state fiscal year. Case management providers who are public state agencies shall have on file an approved cost allocation plan.

Interim rates shall be established in the following manner:

1) The rate for the assessment shall be based on the projected cost of providing the service consistent with methodology in OMB Circular A-87. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

2) The rate for the professional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

3) The rate for the family service worker/paraprofessional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

Cost will be accounted for as follows:

1) Case management staff directly related to the targeted case management program will code all direct time using categories designated for case management functions in 15 minute increments.

2) Any contract costs (i.e., for contracted services) will be based on the actual cost of acquisition of the service.

3) Any indirect costs of any public state agency will be determined using the appropriate cost allocation plan.

Providers will submit cost reports no later than 180 days after the end of the state fiscal year. Interim payments will be adjusted to actual cost based upon review and acceptance of these cost reports in accordance with usual agency procedures.

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT

State: Kentucky

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- OTHER TYPES OF CARE

Payment of Medicare Part A & Part B Deductible/Coinsurance

A. Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a specified rate or method is set out on Page 3 in item B of this attachment (see 3.below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".

3. Payments are up to the amount of a special rate, or according to a special method, described on page 3 in item ____ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on page 3 in item _____ of this attachment (See 3. Above)

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT

State: Kentucky

Payment of Medicare Part A and Part B Deductible/Coinsurance (cont.)

QMBs:	Part A:	SP Deductibles	SP Coinsurance
	Part B:	MR Deductibles	MR Coinsurance
Other Medicaid Recipients	Part A:	SP Deductibles	SP Coinsurance
	Part B:	MR Deductibles	MR Coinsurance
Dual Eligible (QMB Plus)	Part A:	SP Deductibles	SP Coinsurance
	Part B:	MR Deductibles	MR Coinsurance

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT

State: Kentucky

Payment of Medicare Part A and Part B Deductible/Coinsurance (cont.)

B. Medicaid payment for specified Medicare crossover claims will be the lower of the allowed Medicaid payment rates less the amounts paid by Medicare and other payors, or the Medicare coinsurance and deductibles. The specified Medicare crossover claims are defined as: Inpatient Hospital and Nursing Facilities

In the event that Medicaid does not have a price for codes included on a crossover claim the Medicare coinsurance and deductible will be paid.

Medicaid payment for all other allowed Medicare crossover claims will be the amount of the Medicare coinsurance and deductible.

Sub 81-12

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed in Intermediate Care Facilities for the Mentally Retarded in accordance with the following:

A. Payment for the bed reservation shall not exceed the following number of days:

A maximum of fifteen (15) days for a hospital stay for treatment of an acute condition(s), and a total of forty-five (45) days for leave(s) of absence in any given quarter (except that not more than thirty (30) days of such leave may be consecutive days).

B. Payment may ordinarily be made when the following conditions exist:

1. The individual is an eligible recipient and is authorized for Program benefits in the level of care in which he is currently residing.

2. The indivudal is expected to return to the same level of care, barring complications;

3. There is a likelihood that the bed would be occupied by some other patient if not reserved (facilities with a vacancy history would not be reimbursed for reserving a bed);

4. In the case of a leave of absence, the physician orders and the patient's plan of care provides for such an absence.

State Kentucky

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed for skilled nursing and general intermediate care facilities in accordance with the following:

The program will cover reserved bed days in accordance with the following specified upper limits and criteria.

(1) Reserved bed days will be covered for a maximum of fourteen (14) days per absence for a hospital stay with an overall maximum of forty-five (45) days during the calendar year.

(2) Reserved bed days will be covered for a maximum of fifteen (15) days during the calendar year for leaves of absence other than for hospitalization.

(3) Coverage during a recipient's absence for hospitalization or leave of absence is contingent on the following conditions being met:

(a) The person is in Title XIX payment status in the level of care he/she is authorized to receive and has been a resident of the facility at least overnight. For SNFs, persons for whom Title XIX is making Title XVIII co-insurance payments are not considered to be in Title XIX payment status for purposes of this policy;

(b) The person can be reasonably expected to return to the same level of care;

(c) Due to demand at the facility for beds at that level, there is a likelihood that the bed would be occupied by some other patient were it not reserved;

(d) The hospitalization is for treatment of an acute condition, and not for testing, brace-fitting, etc.; and

(e) In the case of leaves of absence other than for hospitalization, the patient's physician orders and plan of care provide for such leaves. Leaves of absence include visits with relatives and friends, and leaves to participate in state-approved therapeutic or rehabilitative programs.